Calendar No. 762

96TH CONGRESS
2d Session

SENATE

REPORT
No. 96-712

THE MENTAL HEALTH SYSTEMS ACT

REPORT

OF THE

COMMITTEE ON LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

TO ACCOMPANY

S. 1177

MAY 15 (legislative day, JANUARY 3), 1980.—Ordered to be printed

U.S. GOVERNMENT PRINTING OFFICE
61-965 O WASHINGTON : 1980

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Public Laws: 96th Congress / 2nd Session / 1980

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MENTAL HEALTH SYSTEMS ACT

MAY 15 (legislative day, JANUARY 3), 1980.—Ordered to be printed

Mr. ROBERT C. BYRD (for Mr. KENNEDY), from the Committee on Human Resources, submitted the following

REPORT

[To accompany S. 1177]

The Committee on Labor and Human Resources, to which was referred the bill (S. 1177) to improve the provision of mental health services and otherwise promote mental health throughout the United States, and for other purposes having considered the same, reports favorably thereon with an amendment and recommends that the bill, as amended, do pass.

I. Summary of the Bill

S. 1177, the Mental Health Systems Act, as reported, revises, beginning in Fiscal Year 1982, the Federal government's approach to funding community-based mental health programs; extends to mental patients a bill of rights and establishes an advocacy program; and revises existing rape prevention and control programs.

TITLE I

Title I of the bill establishes a partnership between local entities and agencies, State governments and the Federal government.

Title I requires that:

1. Each State designate a mental health administrative agency (referred to as the State Agency);

2. Each State Agency divide the State into mental health service areas that are compatible with the boundaries of health service areas established pursuant to Title XV of the Public Health Service Act;

3. The State Health Plan prepared pursuant to Title XV of the Public Health Service Act include identifiable provisions relating to the State's need for mental health services, the special mental health needs of certain groups, the overall adequacy of mental health facilities and services, the mental health priorities in the State, and other matters.

4. Each State Agency prepare, consistent with the State Health Plan, a detailed mental health operations program. This program must describe and evaluate: the need for mental health services the special mental health needs of chronically mentally ill individuals, emotionally disturbed chidren and adolescents, the elderly, and other priority population groups; available mental health facilities and services and the additional facilities and services that are required; the order of priority that will be followed in addressing the defined needs through the use of local, State, and Federal resources; and other matters. In addition, the program must describe in specific terms how mental health care initiated in the State under the Community Mental Health Centers Act will be continued, how comprehensive mental health care throughout the State will be promoted, and how mentally ill individuals deinstitutionalized or diverted from public inpatient psychiatric facilities will be adequately cared for across the State in least-restrictive, community-based settings; and other matters.

The Title also includes provisions for the termination of payments to entities in the State under the Act, after notice and an opportunity for a hearing, if there is substantial and persistent failure of a State to comply with the above requirements.

TITLE II

Title II replaces the existing community mental health centers program with a broader, more flexible, mental health services program.

Under this program, local private nonprofit entities, local public agencies, or State Agencies can apply for Federal funds to provide mental health services or related services in one or more of the following categories:

1. Chronically mentally ill individuals;
2. Severely disturbed children and adolescents;
3. Elderly individuals;
4. Other priority population groups;
5. Prevention of mental illness and promotion of mental health;
6. Community mental health centers;
7. Non-revenue producing services; and
8. Linkages between health care settings and mental health services.

Local entities would be required to submit their application to their respective State Agencies. As with community mental health centers today, all recipients of Federal funding would be subject to annual declining ceilings for such funding (90 percent the first year, 80 percent the second year, etc.).

Title II requires that programs specifically designed for chronically mentally ill individuals must receive certain allocations of available Federal funds, and that 20 percent of all funds spent for community mental health centers must be attributable to the care of chronically mentally ill individuals.

Title II further requires that the Department of Health and Human Services negotiate performance contracts with local entities and agencies or State Agencies prior to the disbursement of funds. These contracts are to describe the population to be served, the project's budget and personnel, standards of performance, data collection procedures, etc. The extent to which the recipient of funds complies with the terms of the performance contract will determine whether the recipient continues to receive funds during the duration of the contract and whether the recipient's request for renewed funding will be accepted.

TITLE III

Title III establishes a bill or rights for mentally handicapped persons admitted to mental health treatment programs and facilities and establishes a mental health advocacy program.

Enforcement of the bill of rights is initially through an administrative grievance process; after exhaustion of applicable administrative remedies, resort to Federal or State courts would be permitted.

TITLE IV

Title IV requires the Director of the National Institute of Mental Health (NIMH) to designate an Associate Director for Minority Concerns.

TITLE V

Title V directs NIMH to establish an administrative unit concerned with the prevention of mental illness and the promotion of mental health, including the establishment of national prevention goals.

TITLE VI

Title VI authorizes appropriations for Fiscal Year 1981 for those sections of the Community Mental Health Centers Act for which the authority to appropriate would otherwise expire at the end of Fiscal Year 1980; authorizes appropriations under Title I of this Act at $400 million for Fiscal Year 1982, $450 million for Fiscal Year 1983, $500 million for Fiscal Year 1984, and the $550 million for Fiscal Year 1985; repeals the planning and formula grant requirements contained in section 314 (g) of the Public Health Service Act and section 237 of the Community Mental Health Centers Act, substituting a similar formula grant program, and authorizes appropriations for this section at $20 million for Fiscal Year 1982 and such sums as may be necessary for Fiscal Years 1983–1985; and authorizes for the programs in Title III $10 million for Fiscal Year 1982 and such sums as may be necessary for Fiscal Years 1983–1985.

TITLE VII

Title VII authorizes appropriations for existing rape prevention and control programs at $6 million for Fiscal Year 1981, $9 million for Fiscal Year 1982, $12 million for Fiscal Year 1983; and establishes and authorizes appropriations for demonstration treatment and training programs at $10.2 million for Fiscal Year 1981, $11 million for Fiscal Year 1982, and $13 million for Fiscal Year 1983.

II. History of the Existing Community Mental Health Centers Program and the Need for New Legislation

A. THE EXISTING COMMUNITY MENTAL HEALTH CENTERS PROGRAM

1. Background: Mental illness and State hospitals

Not until the end of the eighteenth century did the notion emerge that mentally ill individuals should be treated in hospitals. And not until the end of the nineteenth century did the policy of treating the mentally ill in State hospitals become the dominant policy in the United States. The rise of mental hospitals and State responsibility has been described by Ernest M. Gruenberg and Janet Archer of Johns Hopkins University as follows: [1]

> At the end of the eighteenth century, Dr. Philippe Pinel transformed two Parisian madhouses, the Bicêtre and the Salpêtrière, into hospitals for treating the mentally ill. He replaced chains with "moral treatment," which was designed to supply the personal needs of psychotic patients and to arouse their dormant faculties for self-care. Simultaneously in England, a group of Quakers led by William Tuke founded the York Retreat, where they eschewed all restraints and treated their own mentally ill with kindness, "plain talk," and honest efforts to understand and diminish their distress. In the United States in the early nineteenth century, the successes of Tuke and Pinel impressed a number of physicians and social reformers who succeeded in establishing some hospitals based on these models, such as the Hartford Retreat and the McLean Hospital. The high rates of recovery claimed for the small, moral-treatment institutions, in which patients of independent means were seen daily by the superintending physician, produced a "cult of curability" that helped to launch the state mental hospital movement in the United States. . . .
>
> In 1841, when Dorothea Lynde Dix began her crusade on behalf of the mentally ill, there were only eighteen hospitals (state or private) in the United States devoted exclusively to the care of the insane; the vast majority of such cases were in jails and poorhouses, kept at home, boarded out, or auctioned off to the "lowest bidder". . . . Echoing Horace Mann's 1828 plea that the insane be declared "wards of the state," Dix convinced the Massachusetts legislature that local communities had shown themselves incapable of caring for the insane. Like other such reformers, she did not hesitate to reinforce her arguments with the economic lure that decent

[1] Ernest M. Gruenberg and Janet Archer, Department of Mental Hygiene, School of Hygiene and Mental Health, The Johns Hopkins University, "Abandonment of Responsibility for the Seriously Mentally Ill," Milbank Memorial Fund Quarterly/Health and Society, Vol. 57, No. 4, Fall 1979, pp. 485 ff.

> treatment in state hospitals—small and geographically isolated from the stresses of daily life—would cure insane people quickly, making them productive members of society instead of drains on the public purse. In 1843, the legislators voted that all the poor and indigent mentally ill were to be made wards of the Commonwealth of Massachusetts. . . .
>
> The . . . doctrine that the mentally ill are wards of the state reached its most explicit expression with the passage of the New York State Care Act of 1890. This legislation provided for removal of all the insane from local poorhouses and jails to state hospitals, where they were to be supported and treated at state expense, and it required each state hospital to admit all cases of insanity in its district, regardless of prognosis. Following its inauguration in New York, state after state adopted the . . . principle of complete state care for the seriously mentally ill. . . .
>
> Although some state hospitals in the United States were established explicitly as custodial institutions, most attempted to apply moral treatment, and some closely approached that ideal. . . . However, even the best managed hospitals did not long continue to function as the small, rural, therapeutic retreats that Dix and Mann had envisioned. New asylums were built as older ones overflowed, and the demand for accommodation always seemed to exceed capacity. As chronic cases accumulated and new admissions rose, overcrowding led to a deterioration in the standards of care. The "cult of curability" yielded to the notion, "Once insane, always insance"; moral treatment precepts were forgotten, and patients' behavior was controlled with physical restraints and seclusion.

By the end of World War II, at least 80 percent of those people suffering from mental illness were treated in large public institutions operated by the States. The mentally ill not placed in State hospitals were cared for by private practitioners in private settings or were kept at home.

Typically, the State hospitals were underbudgeted and understaffed. Budgets were low even by standards of those days. For example, in the mid-fifties the funds spent for State hospital patient care varied from 0.80 percent to 6.88 percent of total State expenditures. More than half of the States expended less than three percent of their budgets to support State hospitals. By contrast, hospitals operated by the Veterans' Administration fared rather well. Federal support was almost three times that of the States' expenditures. The staff-patient ratio was over two times that found in the State hospitals.

State hospitals were located frequently in rural settings far from concentrations of population. There was an out-of-sight-out-of-mind rationale for the decision to place State hospitals in the country. In addition, their location reflected an attitude that fresh air, opportunity for outside activities, and humane attention to basic needs all constituted the approach of choice in dealing with the nation's emotionally disturbed individuals.

State hospitals represented intact communities providing care not only for those persons institutionalized but meeting most of the needs of hospital staff as well. Thus, there were dormitories, apartments, houses, commissaries, fire and police protection, planned socialization opportunities, church services, and maid service. Patients most often provided the latter.

In these often rural, self-contained settings, the patients were isolated from the community supports of family, church, friends, job, clubs and the like. It was this isolation from community supports that contributed largely to the chronicity of the patient's disturbance and made them increasingly dependent on the State hospital for survival. One study found a direct linkage between years of hospitalization and the chance for release from the State hospital: with four years of hospitalization, there was one chance in twenty of being released.

2. The Impetus for a Community Mental Health Center Program: The decline in State Hospital Population and the Growth of the Community Mental Health Care Movement

The 1940s ushered in the use of somatic therapies, individual and group psychotherapy, psychosurgery, and some attention to a treatment plan. Although recovery rates improved, the State hospital census remained high and continued to grow until the mid 1950s at which time the use of tranquilizing drugs had been generally accepted. Drug treatment resulted in significantly less use of and finally near replacement of the somatic therapies as well as psychosurgery. From 1956 to 1959 there was a decrease in the rate of people hospitalized in State hospitals from 336 to 319 per 100,000 population. This decline has continued ever since and is most notably observed when considering the drop in long-term State mental hospital patients from approximately 600,000 in 1955 to approximately 160,000 in 1978.

At the same time that the widespread use of drugs made it possible to reduce the population of State mental hospitals, a movement to transform these hospitals into back-up centers, and to provide basic care for the mentally ill through facilities and programs located in their home communities, began to emerge. As experiments with mental hospitals in France were the first step toward the growth of State mental hospitals in the United States, experimentation with this community-based approach in Britain paved the way for a community-based approach here. Ernest Gruenberg and Janet Archer, of John Hopkins University recount: [2]

> [In the early 1950s], news began to reach the United States about a new way of making use of mental hospital services. . . . Three pioneer British mental hospital directors (Duncan MacMillan, T. P. Rees, and G. Bell) tried to change the atmosphere in their hospitals by systematically removing locks from doors, removing restraints, and halting involuntary hospitalization. The pattern of hospital life changed. Long-term stays in the community, interrupted by short-term episodes of hospitalization in periods of crisis, replaced

[2] See prior footnote.

long-term hospital stays. The same clinical team of psychiatrists, nurses, social workers, and attendants took responsibility for patient care during both community and hospital phases of care. . . .

It is not easy for those without first-hand experience in mental hospital work to understand what a radical transformation this was. The early nineteenth-century mental hospitals were meant to be short-term, "moral treatment," humane, therapeutic havens. They were intended to replace asylums, which were long-term custodial madhouses, and from the available evidence, they did to a large extent . . . . But by the end of the nineteenth century most of their beds were occupied by permanent residents with a very low probability of being released alive . . . . Custodial functions dominated their operations. "Aftercare" was given to patients "on parole" who showed promise of recovery sufficient to hope that they could be discharged within six months or a year. MacMillan, Rees, and Bell transformed aftercare . . . . By 1954, half of their hospitals' case load was living outside the hospital, so that the hospitals' psychiatrists were spending half of their time caring for patients living in the community. The patients appeared to do dramatically better, showing less chronic troubled or troublesome behaviors. The reports of those British pioneers, describing how they had converted mental hospital practices into a new model of care and treatment, were looked on with suspicion by colleagues familiar with the intractable nature of long-term mental patients. Dr. Robert C. Hunt, who had had years of experience working in New York State mental hospitals, received a World Health Organization fellowship to study these British programs and, partly as a result of his meticulous and dramatic report, New York State Commissioner of Mental Hygiene Paul Hoch appointed a committee of hospital directors to visit them. . . . The committee's reports rereceived much attention. The new community-care, "open-hospital" pattern was a forerunner of what the hospitals should become if the symptomatic relief provided by the new psychopharmaceuticals was to be used constructively . . . .

By the early 1960s, many state mental hospitals in the United States were operating as open hospitals, and some were providing comprehensive services to most of their patients in the community.

Yet, many State mental hospitals were not providing their patients with community-based care. And for the thousands of mentally ill persons who had actually been discharged from or who had never entered State hospitals, but who still needed mental health services, there was little available community-based care other than that provided by private therapists, which many patients could not afford. It was in response to this gap between patient need and available, affordable community-based care that Congress enacted the Health Study Act of 1955 (Public Law 182. Section 304(b)) and created the Joint Commission on Mental Illness and Health.

Members of the Commission were selected by the National Institute of Mental Health and were given the task of assessing the needs of the mentally ill and developing recommendations for a nationwide mental health program. This Congressional mandate led to a five-year study resulting in ten monographs and the final report, *Action for Mental Health.*

The Commission recommended in its report, published in 1961, that:

> Persons who are emotionally disturbed—that is to say, under psychological stress that they cannot tolerate—should have skilled attention and helpful counseling available to them in their community if the development of more serious mental breakdowns is to be prevented.
>
> * * *
>
> Community mental health clinics serving both children and adults, operated as out-patient departments of general or mental hospitals, as part of State or regional systems for mental patient care, or as independent agencies, are a main line of defense in reducing the need of many persons with major mental illness for prolonged or repeated hospitalization. Therefore, a national mental health program should set as an objective one fully staffed, full-time mental health clinic available to each 50,000 of population.
>
> * * *
>
> Expenditures for public mental patient services should be doubled in the next five years—and tripled in the next ten.
>
> Therefore, we recommend that the States and the Federal government work toward a time when a share of the cost of State and local mental patient services will be borne by the Federal government, over and above the present and future program of Federal grants in aid for research and training.
>
> Congress and the National Institute of Mental Health, with the assistance of the intervening administrative branches of government, should develop a Federal subsidy program that will encourage States and local governments to emulate the example set by VA mental and local hospitals.
>
> Certain principles should be followed in a Federal program of matching grants to States for the care of the mentally ill:
>
> The first principle is that the Federal government on the one side and State and local governments on the other should share in the costs of services to the mentally ill.
>
> The second principle is that the total Federal share should be arrived at in a series of graduated steps over a period of years, the share being determined each year on the basis of State funds spent in a previous year.
>
> The third principle is that the grants should be awarded according to criteria of merit and incentive to be formulated

by an expert advisory committee appointed by the National Institute of Mental Health.

President John F. Kennedy asked the Secretary of Health, Education, and Welfare, together with the Secretary of Labor and the Administrator of Veteran's Affairs, to undertake an analysis of the Joint Commission Report and suggest possible courses of action. The President drew heavily on this report in preparing his 1963 Message to Congress on mental health and mental retardation in which he urged creation of a comprehensive community mental health center system.

3. The Community Mental Health Center Program

a. Enactment

On February 5, 1963, in a Message to Congress on Mental Illness and Mental Retardation, President Kennedy recommended a mechanism for creating community mental health centers with the assistance of Federal funds. In his message the President outlined the severity of the problem and its overwhelming cost—not only the direct dollars spent for the care of those affected but the indirect costs of human suffering and loss of human resources. President Kennedy then proposed a "bold new approach" to substitute comprehensive community care for custodial institutional care. He requested that the Congress enact legislation to "1) authorize grants to the States for construction of comprehensive community mental health centers," . . . "2) authorize short-term project grants for initial staffing costs of comprehensive community mental health centers," . . . and "3) facilitate the preparation of community plans for these new facilities as a necessary preliminary to any construction or staffing assistance."

In October 1963, Congress approved and sent to President Kennedy the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (Public Law 88–164). Senate Report No. 180 and House Reports No. 694 and 862 of the 88th Congress were the basis for this legislation. The Senate considered and passed its bill on May 27, 1963. The House considered and passed its bill on September 10, 1963. In the course of the conference, grants for support of professional and technical staff of community mental health centers were deleted. The final conference report provided only for grants for construction. The conference report was agreed to in the Senate and House on October 21 and signed by the President on October 31, 1963.

The new legislation authorized limited Federal financial assistance to States to aid them in the construction of community mental health centers (CMHCs). Such centers, the Congress believed, could be more effective in dealing with the problems of treating the mentally ill than the institutional programs of State and county mental health hospitals scattered across the United States. It was hoped that community-based treatment programs would replace large institutions as the locus for dealing with the mental health problems of the country:

> Either we must develop the quantity and quality of community services which will ultimately replace these institutions or we will have to undertake a massive program to strengthen the State mental hospitals. The committee believes that the development of new methods of treatment, the im-

> pressive evidence of the possibilities for rehabilitating the mentally ill, and a lessening of our disposition to reject and isolate sufferers, all argue strongly for the treatment of mental illness in the community.[3]

The Act gave priority to general hospitals that wished to develop CMHCs as part of their services. Each CMHC was required to provide for a minimum of services that included inpatient, outpatient, partial hospitalization, emergency, consultation and education. Facilities were to be individually designed for the needs of the service or "catchment" area.

Funds were to be used for construction of new buildings, expansion of existing facilities, completion of shell space, initial fixed equipment and movable equipment and furnishings, including transportation vehicles, and architectural fees. One or several buildings could be built. The various services of a center program did not have to be under one roof.

As approved by the President, the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 entitled each of the States to an allotment of Federal funds on the basis of three considerations: (1) population, (2) the extent of facility need, and (3) the overall financial need of the respective States. Each State was required to develop a comprehensive mental health plan. Each State plan was to identify catchment areas of from 75,000 to 200,000 persons, to provide for a statewide system of adequate CMHCs, and to include a list of priorities for action regarding mental health activities in the State. States were also required to provide assurances that the services of CMHCs would be available to all and that a reasonable amount of care would be provided to indigent persons.

Each State was to designate a single State agency as a sole agency for the administration or the supervision of the administration of the State plan. Many States designated construction type agencies—others designated mental health service agencies. State plans were to be submitted for approval.

There was authorized to be appropriated for grants for construction and equipment of community mental health centers: $35 million for the fiscal year ending June 30, 1965, $50 million for fiscal year ending June 30, 1966, and $65 million for the fiscal year ending June 30, 1967. Construction of facilities were partially financed by funds authorized by the Act. Matching monies were to be provided by State and local sources.

b. Amendments

The 1965 Amendments.—In his 1963 Message to Congress on mental illness and retardation, President Kennedy had asked for funds for the purpose of making short-term grants to help meet the costs of initial staffing for community mental health centers. Though such authority was included in the Senate-passed bill, it was deleted from the legislation finally enacted by Congress and signed into law by the President. In January 1965, President Johnson asked the Congress to

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[3] House Report. No. 694, 88th Congress, 1st session; Aug. 21, 1963.

reconsider legislation to help finance a portion of the costs of initial staffing:

> An important beginning toward community preparation has been made through the legislation enacted by the 88th Congress authorizing aid for constructing community mental health centers. But facilities alone cannot assure services. . . . I therefore recommend legislation to authorize a 5-year program of grants for the initial costs of personnel to man community mental health centers which offer comprehensive services.[4]

In response to this request, Congress passed the Community Mental Health Centers Construction Act Amendments of 1965 (Public Law 89–105). Both House Reports 248 and 678 and Senate Report 366 of the 89th Congress addressed the need for grants to assist in staffing CMHCs. On May 4, 1965 the House considered and passed its bill. On June 28, 1965 the Senate considered and passed its bill. The Conference report was agreed to by the Senate and House on July 26 and 27 respectively.

Under the new legislation, grant funds were made available for the initial staffing cost incurred by centers constructed under the 1963 program and for similar costs for centers already in existence which were proposing to add new or additional mental health services. The legislative history makes it clear that Congress intended such assistance to be limited in scope and brief in duration:

> It is not the intention of the committee that the Federal Government will assume the traditional responsibility of the States in this field. However, it is the committee's considered view that it is the proper role of the Federal Government to give its financial assistance in this transitional period.[5]

To achieve this objective, grants were authorized on a decreasing matching basis for a period of 51 months, as follows: 75% of the costs of professional and technical personnel covered for 15 months, 60 percent of the costs for the next 12 months, 45% for the next 12 months, and 30% for the last 12 months. The 1965 Amendments also required that:

The applicant had to be a public or non-profit private agency or organization.

Services were to be provided by the CMHC, alone or in conjunction with other facilities affiliated with it, as part of a program of mental health services to be delivered to a predefined catchment area.

Services provided were to constitute a comprehensive mental health service program, including as essential mental health services inpatient, outpatient, emergency, partial hospitalization, and consultation and education.

Individual applicants' proposals had to be consistent with comprehensive State Mental Health plans.

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[4] "Advancing the Nation's Health," Special Message to the Congress, Jan. 7, 1965.
[5] Senate Report No. 366, 89th Congress, 1st session, June 24, 1965.

Funds were to be distributed in a manner which took into account the relative needs of the several States for CMHCs, their relative financial needs and their populations.

Funds were to be expended for new services which are genuinely new in scope and content and not merely substitutes for old. A provision for "maintenance of effort" was thus included. Federal funds were not to supplant non-Federal funds.

The 1965 Amendments authorized staffing funds amounting to a total of $73.5 million for fiscal years 1966–1968.

The 1967 Amendments.—In June 1967, Congress again altered the CMHC program by enacting the Mental Health Amendments of 1967 (Public Law 90–31). The legislation extended the authorizations for the construction and initial staffing grant programs already enacted and amended the definition of the term "construction" to permit the acquisition of existing buildings for use as CMHCs.

The 1967 Amendments authorized construction funds totalling $180 million for fiscal years 1968–1970, and an additional $58 million for initial staffing grants for the same period.

The 1968 Amendments.—In October 1968, the scope and purposes of the Community Mental Health Centers Act were broadened by adding construction and initial staffing assistance for centers and other specialized facilities for the treatment of alcoholism and narcotic addiction. Under the Alcoholic and Narcotic Addict Rehabilitation Amendments of 1968 (Public Law 90–574), facilities were entitled to assistance in amounts not to exceed two-thirds of the costs of construction. Staffing grants were also available on a declining Federal share basis. Congress also authorized States (subject to a "maintenance of fiscal effort" provision) to use 2 percent of their allotment funds (not to exceed $50,000) to meet the costs of program administration.

The 1968 Amendments authorized a total of $40 million for fiscal years 1969 and 1970, for the various construction, staffing, training and evaluation programs included in the Alcoholic and Narcotic Addict Rehabilitation Amendments.

The 1970 Amendments.—Originally, the CMHC program had been designed to provide basic "seed" money for the purposes of constructing community facilities and helping centers meet their initial costs of operation. But in 1970, Congress concluded that State and local sources of funding had proved to be inadequate in "picking up" the costs of operating CMHCs and that additional financial support would be needed to continue and promote the development of center programs throughout the United States.

Hearings on a reauthorization bill were held by the Subcommittee on Health of the Committee on Labor and Public Welfare, U.S. Senate, on July 28 and 30, 1969 with Report No. 91–583 issued on December 8, 1969; the bill was considered and passed by the Senate on December 11, 1969. The Subcommittee on Public Health and Welfare of the Committee on Interstate and Foreign Commerce, U.S. House of Representatives, held hearings on several bills to extend the program, releasing Report 91–735 on December 10, 1969; the legislation was considered and passed by the House on December 16, 1969. On February 25, 1970, a conference report was issued. The CMHC Amendments of 1970 (Public Law 91–211) were enacted on March 13, 1970.

The House Report had noted that:

> Earlier optimism regarding the progressive development of funding resources through Federal health insurance and medical assistance programs, private insurance plans, and other third-party payments proved too optimistic. . . . During the early years of the program, it has become increasingly clear that the localities in the greatest need of community-based mental health services, the urban and rural communities of low economic status, have been least able to organize, plan and raise sufficient funds to develop programs eligible for Federal grant support.[6]

Accordingly, under the Community Mental Health Centers Amendments of 1970, the Federal share of the costs of center construction was increased. The declining Federal matching formula used to determine the share of staffing was also changed. Centers not in poverty areas were now entitled to grants over an 8 year period (rather than for 51 months) at the new rates shown in the following table. Centers located in poverty areas received assistance for the same period of time (8 years), but at the more favorable rate shown in the table. The ratios also applied to facilities serving alcoholics and narcotic addicts.

AUTHORIZED MAXIMUM FEDERAL MATCHING SHARES

[In percent]

	Year							
	1	2	3	4	5	6	7	8
Nonpoverty area	75	75	60	45	30	30	30	30
Poverty area	90	90	80	75	75	70	70	70

A number of other changes were made by the 1970 Amendments. The percentage of State allotments authorized to meet administrative costs was raised from 2 to 5 percent, although the overall limit of $50,000 was retained. A new program of initiation grants was added for the purpose of assessing local needs for mental health services, designing center programs, developing services and for other purposes. A new program for children's mental health services was incorporated into the Act, including construction and staffing assistance and grants for training and evaluation purposes. Funds were authorized for consultation services provided in centers and specialized treatment facilities. Also added was a program of direct grants for special projects relating to alcoholism and narcotic addiction.

The 1970 Amendments authorized $270 million for center construction and $155 million for initial staffing purposes for fiscal years 1971–1973. Initiation grants were to be funded from appropriations authorized for staffing grants. The new children's mental health services program contained authorizations totaling $62 million, while $15 million was provided to meet the costs of consultation services. The alcoholic and narcotic addict rehabilitation and treatment programs were also extended for the same period with authorizations amounting to $105 million.

Related Alcoholism and Drug Abuse Amendments.—Two other laws enacted by Congress in 1970 amended programs included in the Com-

[6] House Report No. 91–735, 91st Congress, 1st session ; Dec. 10, 1969.

munity Mental Health Centers Act. The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (Public Law 91–616) authorized additional programs of grants and contracts for the prevention and treatment of alcoholism and required that such projects be community-based wherever possible. The Comprehensive Drug Abuse Prevention and Control Act of 1970 (Public Law 91–513) increased the level of authorizations for selected alcoholic and narcotic addict rehabilitation programs, authorized funds for programs of drug abuse education, and authorized special project grants for the treatment of drug addiction. The Drug Abuse Office and Treatment Act of 1972 (Public Law 92–255) required centers, where possible, to provide treatment and rehabilitation programs for addicts and others with drug dependency problems.

The 1973 Amendments.—The CMHC program was reauthorized for one year in the Health Programs Extension Act of 1973 (Public Law 93–45, June 18, 1973).

The 1975 Amendments.—In its review of the program in 1974, the Congress determined that, because of the patchwork history of the program, it was necessary to provide a clear definition of a CMHC and prescribe the comprehensive mental health services which such a center must provide in order to be eligible for funding. The definition contained requirements regarding the organization and operation of a CMHC, provision of services, coordination of services with other entities, development of an integrated system of care, staffing, availability of services, responsiveness to the community served, governing bodies, and quality assurance. The new definition also required each CMHC to provide all stipulated services as a condition to receiving support. These requirements were incorporated into the extensive revision of the Community Mental Health Centers Act accomplished under the Health Revenue Sharing and Health Services Act of 1975 (Public Law 94–63).

Senate Bill S66 and House of Representative Bill HR 4925 had differences which were referred to a conference committee. The Senate Bill, S66, was considered and passed by the House as amended. On June 5, another conference to resolve differences ensued. The Senate agreed to the final conference report on July 14; the House agreed to it on July 16. The President vetoed it on July 26. The Senate overrode the veto the same day and the House did so on July 29, the date it was enacted into law.

The new law, in redefining the CMHC, imposed requirements related to concept, quality, and comprehensiveness:

> A community mental health center was to be a public or private nonprofit legal entity through which comprehensive mental health services were provided principally to individuals living in a defined geographic area (catchment area).
>
> Within the limits of the center's ability, it was to provide services to any individual living in or employed in its catchment area regardless of his or her ability to pay for such services, current or past health condition, or any other factor.
>
> A community mental health center should ensure that persons receiving services have access to all health and social services they may require.

Mental health services through the community mental health center were to coordinate with the services of other health and social agencies, including State mental health facilities, serving residents of the center's catchment area.

Services were to be available and accessible to the residents of the area promptly, as appropriate, and in a manner which preserves human dignity and assures continuity of high quality care and which overcomes geographic, cultural, linguistic, and economic barriers.

Services were to be available 24 hours a day and 7 days a week.

A community health center must have a governing body composed of individuals who reside in the center's catchment area and who, as a group, represent the residents of that catchment area.

A community mental health center shall have established an ongoing quality assurance program, an integrated medical records system, a professional advisory board, and an identifiable administrative unit to provide the required consultation and education services.

The number of required services was expanded from five to twelve, to be provided at the center or satellite facilities through the staff of the center or through appropriate arrangements with health professionals and others in the center's catchment area. The twelve services were:

(1) inpatient services;
(2) outpatient services;
(3) partial hospitalization services;
(4) emergency services;
(5) consultation and education services;
(6) services for children;
(7) services for elderly;
(8) screening services;
(9) followup care;
(10) transitional services;
(11) alcoholism and alcohol abuse services; and
(12) drug addiction and drug abuse services.

The 1975 Amendments required all existing centers as well as new centers to meet the revised definition and requirements within two years, as a condition of obtaining or continuing to receive grant support. It also created the National Center for the Prevention and Control of Rape, which conducts research into the legal, social, and medical aspects of rape.

At the time of the 1975 Amendments, concern was expressed about the financial viability of CMHCs following their eighth and final year of Federal operations support. This concern was particularly acute in view of the limited third party payments available to such centers under the Medicaid and Medicare programs and most private insurance plans. For that reason, a program of financial distress grants was devised which authorized grants to be made to centers experiencing financial distress if such centers agreed to comply with additional requirements to assure that reforms designed to relieve that distress

without curtailing services would be instituted. A provision was included that no center could receive more than three such awards.

Two other grant mechanisms were also established by the 1975 Amendments: (1) conversion and (2) consultation and education. The purpose of the conversion grant program was to assist existing centers in meeting the initial costs of instituting those new services required by the 1975 amendments. Conversion grants were to be available for up to 2 years for each such center.

The second new categorical authority, consultation and education, was to be available to centers on an annual basis beginning their fifth year of operations. At the time of the enactment of the 1975 Amendments, the Congress expressed concern that consultation and education was a vital program element for which third party reimbursement was unavailable. This new authority was developed as an appropriate mechanism to assure its provision.

The 1977 Amendments.—The CMHC program was again reauthorized for one year in 1977 (Public Law 95–83, August 1, 1977) as part of legislation which extended through Fiscal Year 1978 the authorizations for the Community Mental Health Centers Act as well as for other legislation. The intent of this one-year extension was to enable the Congress to examine the program in depth to ascertain what changes and improvements were needed.

The 1978 Amendments.—The Community Mental Health Centers Extension Act of 1979 (Title I of Public Law 95–622, November 9, 1978) reauthorized the CMHC program for two years, through Fiscal Year 1980. It provided for immediate availability to all age groups of six basic CMHC services, as follows: inpatient; emergency; outpatient; court screening and referral; follow-up; and consultation and education. The other mandated services—day care and partial hospitalization; special services including transitional halfway houses; services for children and the elderly; and alcohol and drug abuse services (unless waived by the Secretary)—could be phased in over three years. The Act further permitted, contingent upon the Secretary's approval, cross-catchment area sharing of inpatient, emergency, and halfway house services.

The amendments required centers, other than those directly operated by a hospital or governmental agency, to establish a citizens governing board. These boards approve a CMHC's annual budget and establish general policies for the center. A hospital or governmental agency may appoint an advisory committee in lieu of a governing board.

The authorization of appropriations for financial distress grants was increased in Fiscal Year 1979 to $25 million. Rather than three, five years of support are now permitted.

Up to one percent of CMHC appropriations under Sections 203, 204, and 205 could be used by HEW for contracts with State mental health authorities to monitor federally funded and non-State-operated centers.

In certain circumstances there could be a carryover of funds, reducing correspondingly the Federal grant award for the following year.

With respect to grants awarded for initial operations and staffing, from Fiscal Year 1979 and subsequent appropriations grantees could retain a financial reserve up to five percent of the non-Federal grant

funds (State, local, and other monies; fees, premiums and third-party reimbursements) produced in excess of the projected costs of operation in any fiscal year.

c. Implementation

Program Growth.—In his February 5, 1963 Message to Congress, President Kennedy called for "forceful and far-reaching programs" to be carried out at all levels of government in every part of the Union, stating:

> We must act—
>
> To bestow the full benefits of our society on those who suffer from mental disabilities;
>
> To prevent the occurrence of mental illness and mental retardation wherever and whenever possible;
>
> To provide for early diagnosis and continuous and comprehensive care, in the community, of those suffering from these disorders;
>
> To stimulate improvements in the level of care given the mentally disabled in our State and private institutions, and to reorient those programs to a community-centered approach;
>
> To reduce, over a number of years, and by hundreds of thousands, the persons confined to these institutions;
>
> To retain in and return to the community the mentally ill and mentally retarded, and there to restore and revitalize their lives through better health programs and strengthened educational and rehabilitation services; and
>
> To reinforce the will and capacity of our communities to meet these problems, in order that the communities, in turn, can reinforce the will and capacity of individuals and individual families.
>
> We must promote—to the best of our ability and by all possible and appropriate means—the mental and physical health of all our citizens.

Since that historic plea for those suffering from mental disabilities, the CMHC Program has reached 105 million persons with a Federal investment of $2.232 million. There is now an extensive network of CMHCs covering approximately half of the nation.

Since the beginning of the program in 1963, the National Institute of Mental Health has funded a total of 763 centers: 95 with construction grants only, 281 with staffing or operations grants, and 387 with both constuction and staffing or operations grants.

To date, 744 centers are fully operational, providing the required services and, in many cases, additional programs designed to meet the special needs of their communities.

The annual rate of growth of CMHCs during this period is shown in Table 1.

Federal grants from the National Institute of Mental Health have been made to centers in all 50 States, Puerto Rico, the Virgin Islands, Guam and the District of Columbia. See Table 2.

TABLE 1.—HISTORY OF CMHC PROGRAM—FEDERALLY FUNDED CMHC'S

	Number centers 1st aided in year by—				Cumulative total end of year						
	88–164 construction	220 staff	94–63 operation	Switch staff to operation	Construction onl	Construction and staff	Construction and operation	Staff only	Operation only	Total	Operation end year
Fiscal year:											
1966	96	55	----------	----------	75	21	----------	34	----------	130	----------
1967	93	68	----------	----------	137	52	----------	71	----------	260	----------
1968	62	33	----------	----------	175	76	----------	80	----------	331	104
1969	30	57	----------	----------	163	118	----------	95	----------	376	175
1970	22	42	----------	----------	165	138	----------	117	----------	420	245
1971	46	29	----------	----------	168	181	----------	103	----------	452	300
1972	2	79	----------	----------	130	221	----------	142	----------	493	325
1973	35	0	----------	----------	151	235	----------	128	----------	514	380
1974	27	126	----------	----------	102	311	----------	178	----------	591	443
1975	30	0	----------	----------	114	329	----------	160	----------	603	507
1976 and transition quarter	35	0	42	2	120	345	14	141	30	650	547
1977	0	0	37	40	108	312	59	134	62	675	592
1978	0	0	56	36	102	292	88	118	126	726	625
1979	0	0	37	24	95	278	109	110	171	763	744

TABLE 2.—TOTAL FEDERAL OBLIGATIONS FOR CMHC'S (BY STATE), FISCAL YEARS 1965 THROUGH 1979

State	Construction	Staffing	Children	Operation	Conversion	Distress	C. & E.	State total
U.S. total	251, 129, 801	1, 246, 754, 739	160, 134, 434	465, 089, 623	63, 542, 278	24, 261, 553	27, 883, 764	2, 238, 796, 192
Alabama	5, 760, 093	19, 842, 362	2, 060, 572	14, 305, 999	2, 865, 065	127, 500	273, 744	45, 235, 335
Alaska	89, 040	871, 192		2, 990, 007				3, 950, 239
Arizona	1, 882, 679	20, 144, 022	4, 357, 198	3, 282, 878	2, 818, 427	750, 000	458, 882	33, 694, 086
Arkansas	4, 339, 828	36, 329, 076	5, 521, 135	5, 566, 942			258, 571	52, 015, 552
California	21, 392, 045	124, 959, 821	17, 142, 023	28, 313, 869	7, 021, 714	2, 475, 037	3, 005, 968	204, 310, 477
Colorado	2, 484, 006	28, 003, 714	3, 784, 753	9, 726, 403	3, 063, 304	1, 210, 582	343, 980	48, 616, 742
Connecticut	3, 379, 753	10, 425, 231	1, 531, 158	2, 910, 929			167, 610	18, 414, 661
Delaware	741, 757	5, 488, 972	373, 983			152, 000		6, 756, 712
District of Columbia	727, 286	14, 693, 025	673, 206	871, 734				16, 965, 251
Florida	9, 078, 821	55, 229, 109	6, 567, 686	21, 688, 113	4, 276, 618	1, 057, 415	1, 081, 102	98, 978, 864
Georgia	7, 437, 081	25, 737, 368	1, 046, 106	11, 830, 496	487, 383	41, 000	241, 705	46, 821, 139
Hawaii	1, 329, 334	2, 937, 634	2, 012, 317	1, 534, 283				7, 813, 568
Idaho	1, 096, 731	13, 978, 412						15, 075, 143
Illinois	9, 923, 314	22, 615, 923	3, 422, 652	16, 985, 991		3, 085, 371	1, 628, 607	57, 661, 858
Indiana	6, 489, 534	33, 572, 783	5, 321, 356	36, 674, 444	2, 887, 181		215, 557	85, 160, 855
Iowa	4, 509, 972	846, 799	529, 215				227, 037	6, 113, 023
Kansas	2, 507, 521	15, 903, 150	1, 707, 150	10, 087, 720	291, 143		443, 400	30, 946, 084
Kentucky	5, 292, 131	63, 266, 751	5, 193, 054		2, 963, 828	1, 658, 230	2, 081, 182	80, 455, 176
Louisiana	6, 267, 512	10, 220, 211	1, 184, 729			272, 000		17, 944, 452
Maine	1, 105, 089	18, 053, 394	2, 318, 388	4, 669, 852	1, 754, 747	483, 783	659, 826	29, 045, 080
Maryland	4, 801, 150	12, 803, 289	300, 770	1, 760, 456			70, 417	19, 736, 082
Massachusetts	6, 943, 688	40, 574, 825	10, 463, 680	13, 368, 751	3, 339, 031	807, 369	1, 631, 220	77, 128, 564
Michigan	8, 936, 746	30, 235, 205		8, 268, 627	658, 718		300, 608	48, 399, 904
Minnesota	4, 008, 837	10, 438, 068	1, 789, 748	1, 645, 024	534, 637	65, 000	924, 965	19, 406, 279
Mississippi	3, 221, 035	16, 798, 308	1, 321, 944	6, 003, 972	3, 291, 600	348, 288	596, 027	31, 581, 174
Missouri	5, 624, 385	24, 381, 975		17, 634, 789	576, 051		311, 275	48, 528, 475
Montana	708, 343	7, 801, 636	1, 891, 639		225, 364	635, 357		11, 262, 330

Nebraska	1, 985, 425	10, 137, 552	2, 047, 247	4, 617, 888	1, 209, 725	528, 989	212, 759	20, 739, 585
Nevada	[illegible]	3, 019, 378	537, 603	7, 277, 922	583, 094	----------	----------	12, 296, 515
New Hampshire	1, 440, 813	3, 572, 564	401, 528	9, 055, 018	1, 380, 765	----------	----------	15, 850, 688
New Jersey	8, 043, 696	61, 169, 692	6, 149, 274	11, 006, 227	135, 890	----------	448, 892	86, 953, 671
New Mexico	1, 067, 235	11, 051, 648	1, 226, 355	6, 568, 416	605, 483	762, 600	716, 965	21, 998, 702
New York	19, 741, 413	84, 249, 539	7, 980, 548	19, 028, 176	725, 254	2, 449, 332	871, 525	135, 045, 787
North Carolina	7, 331, 959	21, 200, 410	4, 522, 409	16, 383, 941	845, 232	444, 811	527, 283	51, 256, 045
North Dakota	885, 263	5, 259, 691	3, 489, 942	----------	1, 445, 328	623, 908	867, 858	12, 571, 990
Ohio	13, 071, 771	35, 404, 999	7, 344, 960	33, 899, 292	3, 822, 243	----------	295, 536	93, 838, 801
Oklahoma	2, 698, 881	16, 683, 161	2, 585, 462	7, 585, 120	799, 634	1, 243, 503	436, 160	32, 021, 921
Oregon	641, 214	9, 924, 635	----------	1, 975, 112	----------	----------	----------	12, 540, 961
Pennsylvania	15, 943, 102	128, 413, 112	8, 758, 661	30, 382, 489	4, 659, 006	1, 436, 871	3, 296, 291	192, 889, 532
Puerto Rico	5, 157, 716	13, 297, 659	1, 519, 140	9, 001, 869	829, 007	----------	201, 380	30, 006, 771
Rhode Island	864, 435	8, 083, 639	----------	4, 761, 422	----------	----------	----------	8, 709, 496
South Carolina	4, 982, 731	15, 163, 307	5, 218, 451	7, 020, 264	860, 128	812, 496	624, 025	34, 681, 421
South Dakota	593, 304	977, 673	----------	4, 554, 440	296, 000	----------	----------	6, 421, 417
Tennessee	5, 486, 634	19, 491, 378	4, 888, 048	11, 890, 556	----------	----------	475, 895	42, 322, 511
Texas	9, 310, 342	59, 947, 105	8, 520, 583	21, 460, 731	5, 250, 088	390, 000	989, 622	102, 868, 471
Utah	715, 816	11, 788, 091	1, 460, 500	5, 609, 335	1, 000, 040	250, 760	1, 477, 813	22, 362, 355
Vermont	1, 042, 240	6, 361, 315	2, 489, 413	2, 008, 888	453, 023	639, 886	118, 784	13, 113, 549
Virginia	6, 335, 750	13, 442, 035	1, 135, 551	9, 772, 340	173, 000	----------	----------	30, 878, 676
Washington	3, 634, 463	13, 898, 694	4, 336, 729	10, 997, 233	270, 274	908, 270	845, 458	33, 981, 121
West Virginia	3, 009, 693	16, 772, 706	1, 879, 791	8, 543, 284	294, 307	----------	227, 054	30, 726, 835
Wisconsin	5, 798, 262	9, 857, 232	1, 872, 471	558, 717	----------	----------	338, 781	18, 425, 463
Wyoming	371, 590	3, 267, 720	703, 350	874, 845	----------	610, 195	----------	5, 818, 700
Guam	9, 824	1, 173, 795	551, 976	1, 034, 818	----------	----------	----------	2, 770, 413
Virgin Islands	----------	1, 987, 754	----------	----------	789, 946	----------	----------	2, 777, 700

States with highest number of federally funded centers:

California	55	North Carolina	27
Pennsylvania	46	Ohio	27
Texas	35	Georgia	25
Florida	34	Michigan	24
New York	28		

Program Accomplishments.—Data developed by the NIMH shows steadily increasing CMHC caseloads from the program's inception to the present. A high percentage of admissions to CMHCs are persons with severe mental disorders that, prior to the CMHC program, would have to be sent to State and mental hospitals.

Further details are provided in the following highlights from the NIMH CMHC program report for the last year, 1977–1978, for which there is completed data.[7]

Caseload.—There were an estimated 834,000 persons in treatment in CMHCs at the beginning of the 1977 reporting year to which were added an estimated 1.05 million during the year. This computes to an average of 3,342 persons under care per CMHC during 1977. Since 1968, the annual caseload of CMHCs has more than doubled, increasing from 1,646 in 1968 to 3,342 in 1977.

Utilization Indices.—An estimated total of 269,000 episodes of inpatient care, 140,000 episodes of partial care and 1.7 million episodes of outpatient care were provided by the CMHCs during 1977. This averages out to 478 episodes of inpatient care, 249 episodes of partial care and 3,094 episodes of outpatient care per center. Since 1969, inpatient episodes as a percent of total episodes have steadily decreased from 18 percent in 1969 to 13 percent in 1977, counterbalanced by increases in partial and outpatient care.

Source of referral to the CMHC—The major referral source to the CMHCs is now, and has always been, the individual, family, or friend. Referrals from this source, social or community agency, court, law enforcement or correctional agency and from other referral have increased as a percent of total referrals over the years. This has meant a relative decrease in percent referrals from psychiatric and medical sources (facilities as well as private practitioners).

Source of referral on discontinuation from the CMHC—Only 24 percent of the persons discontinued from services in the CMHC program during 1977 were referred to other service providers or community caretakers. Of those that were not referred, 36 percent dropped out of the program and 25 percent were reported to be no longer in need of further treatment.

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[7] The descriptive data on federally-funded community mental health centers for 1977–1978 are based on a stratified random sample of the Inventory of Comprehensive Community Mental Health Centers conducted by the Division of Biometry and Epidemiology, National Institute of Mental Health, in cooperation with the State Mental Health Authorities.

The total universe for 1977–1978 represents 563 federally-funded centers in operation prior to January 1, 1977 plus a portion of those starting to operate between January 1 and June 30, 1980. All centers that began operation January 1, 1980 or thereafter were contacted to determine, if requested to submit data, whether the center would report on a fiscal year or calendar year. Of those centers, the universe included only the ones that would have reported a minimum of seven months of data.

Data on patient characteristics, caseload, expenditures, and funding are reported by the CMHCs for either the calendar year 1977 or FY 1977 but are combined. Data on staffing patterns and consultation and education are as of February 1978.

Characteristics of additions to CMHC's.—Of the estimated 1.05 million persons added to the CMHC program during 1977, 81 percent were white and 19 percent were all other races, 49 percent were males and 51 percent were females. Children (under 15 years old) comprised 15 percent of the additions and those 65 years of age and over comprised 4 percent. Since 1969, the percent of additions under 15 years of age has fluctuated, increasing from 13 percent in 1969 to 17.2 percent in 1972 and decreasing subsequently to 14.5 percent in 1977. The more severe mental disorders (viz., schizophrenia, depressive disorders, mental retardation, other psychoses) along with alcohol disorders and drug abuse comprised 46 percent of all admissions to the CMHCs.

Indirect Services.—During the month of February 1978, CMHC staff devoted an estimated total of 231,117 hours in consultation and public information and public education. This amounted to an average of 2.6 FTE staff devoted to these efforts (1.8 FTE's to consultation and 0.8 FTE to public information and public education).

Staff.—As of February 1978, there were an estimated 70,496 persons employed in the federally-funded CMHC program, that is, personnel supported by reported CMHC budgets. As a result of CMHC contracts and affiliation agreements with other mental health facilities, an unknown number of additional staff have provided mental health services to center enrolled clients as a part of the centers' comprehensive services delivery system. The average staff per center, maintained by the center's budget, numbered 125 persons. In terms of staff hours or full-time equivalent (FTE) staff, four percent were psychiatrists and other physicians, nine percent were psychologists (B.A. and above), 13 percent were social workers (B.A. and above), ten percent were registered nurses, 18 percent were mental health workers (less than B.A.), and the remainder clinical, business, and maintenance staff.

Expenditures.—An estimated $990 million were spent during the 1977 reporting year by the 563 operating federally-funded centers as follows: personnel costs accounted for roughly 62 percent; other operating expenditures, 32 percent; the purchase of services for center clients, about 4 percent; and 2 percent were reported as capital expenditures.

Sources of Funds.—Total receipts from all sources per center averaged about $1.7 million. Of this total, roughly 61 percent were reported as Government funds, 36 percent were earned revenues (i.e., receipts from direct services) and 3 percent originated from other sources. Centers are showing an increasing capacity to generate third-party reimbursements although to date these sources of revenue still amount to less than one-third of total receipts. Receipts from services increased from 16 percent of total receipts in 1969 to 36 percent in 1977.

B. THE NEED FOR NEW LEGISLATION

Since its inception in 1963, the community mental health centers program has accomplished much. But it has also suffered from shortcomings, which the General Accounting Office, the Inspector General

of the Department of HEW, and others have described. Some of these shortcomings have been corrected by administrative action, some through the Congressional amendment process. Both the shortcomings and corrective actions are described in part one of this section.

During the late 1970s, however, it became clear that such mid-course corrections were not enough. A consensus emerged that the CMHC program was not providing—and could not provide under its existing statutory framework—adequate mental health treatment and care for chronically mentally ill individuals, severely disturbed children and adolescents, elderly persons, and others with special needs. A consensus also emerged that the CMHC program did not—and could not within the terms of its statutory framework—provide a truly integrated local-State-Federal mental health system. The need for restructuring the CMHC program was detailed in the Report of the President's Commission on Mental Health, which was issued in 1978. The Report is summarized in part two of this section.

At the same time, a separate consensus was developing that mentally ill individuals would never be fully secure in the enjoyment of their rights until those rights were recognized in Federal law and were protected by means of an effective advocacy system. This was supported by the interdisciplinary Task Panel on Legal and Ethical Issues of the President's Commission on Mental Health. Part three of this section discusses rights and advocacy programs.

Finally, part four of this section concludes that although much has been accomplished under the Community Mental Health Centers Act, that legislation no longer provides a sufficient vehicle for dealing with the mental health needs of 1980s, and enactment of the Mental Health Systems Act is now necessary.

1. Past Shortcomings of the Community Mental Health Center Program—and Responses by HEW and Congress

General Accounting Office (GAO) Studies

A number of GAO studies have focused on the CMHC program. The 1971 GAO report, *The Community Mental Health Centers Program—Improvements Needed in Management* (B–164031(2)), noted that program planning was inadequate at both the HEW and State levels, HEW had not set goals for implementing the program, and grant funds for both construction and staffing were either greater than warranted or used to cover unauthorized costs. In the 1974 GAO report, *Need for More Effective Management of Community Mental Health Centers Program* (B–165031(5)), it was pointed out that many of the same problems still existed.

In addition to the above reports, the 1977 GAO report, *Returning the Mentally Disabled to the Community: Government Needs to Do More* (HRD–76–152), noted that central to the process of returning the mentally disabled to the community is the availability of adequate community services. This report also discusses the role the CMHCs have played in the deinstitutionalization process.

By October 1, 1978, approximately 745 grantees had received planning, construction, and initial operations grants, and 624 centers were in operation. Of these, 268 had already completed 8 years of funding. The 1979 GAO study, entitled *Legislative and Administrative*

Changes Needed in Community Mental Health Centers Program (B–164051(5)), focused on this universe of CMHCs and indicated that administrative and legislative changes must be made if the goal of a national network of community mental health centers were to be realized within the foreseeable future. For this planned network to be completed, GAO concluded that either:

More funds must be made available to begin new centers;

A limit must be placed on the maximum grant amount to each center so that the available funds can be awarded to more centers;

The number of required services must be reduced; or

Some alternative method of funding, such as increased third-party payments, must be found.

More recently a GAO study was launched to study mental health services to prison populations. The study report, *Prison Mental Health Care Can Be Better Management and More Effective Federal Aid*, has not been completed as yet.

The GAO studies have had considerable impact on the CMHC program. Some identified problems have resulted in new programs or emphases such as the Community Support program designed to focus on the deinstitutionalized population and the development of a national plan for the chronically mentally ill. The latter was given further impetus by the President's Commission on Mental Health. Other problems identified by GAO have been addressed through legislation, especially the 1978 amendments.

Inspector General's Studies

In November 1978, the Inspector General (IG) of the Department of HEW initiated a Service Delivery Assessment (SDA) of community mental health centers. The function of the SDA was to provide HEW's top managers with information on the nature of services delivered at the client level, their relationship to community and client needs, and conditions and subjective aspects of service delivery that are important but cannot be readily quantified. The Boston Regional Office of the IG's Office of Service Delivery Assessment (OSDA) was responsible for this study.

This SDA focused on the centers from two different vantage points: 1. that of the clients being served, and 2. that of the organizational interactions between centers and other human service agencies.

The information collected came from three major sources: site visits to 16 federally funded community mental health centers in 7 States in Regions I, VI, VII, IX; individual discussions with 755 individuals, including State and local officials, professional and lay persons and patients; and case histories.

In June 1979, the OSDA produced a document that recommended that HEW:

1. assume much more assertive and imaginative roles in fostering service delivery linkages between CMHCs and health care providers;

2. recognize and help others recognize that the advantages associated with closer CMHC—health sector ties can involve not only greater service effectiveness and efficiency, but also better outreach to underserved groups;

3. promote within the human services environment a greater appreciation of the diverse "career" patterns and needs of the chronically mentally ill;

4. encourage and facilitate the development of the CMHC affiliated "psychosocial" clubs for the chronically mentally ill;

5. explore ways of making the SSI disability program more attuned to the needs of the chronically mentally ill;

6. continue and further develop HEW–HUD joint initiatives directed to the housing needs of the chronically mentally ill;

7. continue to encourage and facilitate stronger State leadership with respect to the deinstitutionalization and community based care of the chronically mentally ill;

8. use NIMH evaluation dollars and/or other available resources to explore CMCH staffing trends and the compatibility of these trends with the broadened mission of CMHCs;

9. foster among CMHCs a greater appreciation for systems roles and for how to carry them out; and

10. use NIMH evaluation dollars to learn more about adult outpatient users who are not chronically ill, but who have multiple and longstanding human service needs.

The NIMH incorporated the recommendations of this study into its planning for and development of new legislation.

In November 1979, staff of the Inspector General's Office initiated another study of CMHCs. Their objective was to study the management practices in CMHCs and Regional Offices. CMHCs in four States and the DHEW Regional Offices for those States were selected for site visits. The questionnaire and/or study guide was not submitted to or reviewed with the staff of NIMH prior to these visits. The NIMH has not received any interim reports on these visits or study to date.

Consumer Group Study of the CMHC Program

One of the most publicized studies of CMHCs was done by Ralph Nader's public interest research group. It was later published as a book, *The Madness Establishment*, by Franklin D. Chu in 1974. The Nader group's objective was to study the National Institute of Mental Health and the responsiveness of its programs to the public. A major portion of the study was devoted to the CMHC program. The study examined seven CMHCs. The investigator found that, in each center, despite community involvement, control remained with the providers of services.

The claim of inadequate public responsiveness by the CMHC program was accepted by Congress, which amended the law in 1978 to require citizen-dominated governing boards for most CMHCs and citizen-dominated advisory boards for the remainder.

1975 House of Representatives Report

The Surveys and Investigations Staff of the Committee on Appropriations of the House of Representatives conducted an investigation in 1975 to determine (1) whether Federal funds were being used as effectively as possible to carry out the objectives of the CMHC program, (2) the depth and extent of review prior to grant award determinations, and (3) the adequacy of standards and regulations under which such grant awards were made. The study also addressed

whether approved grant projects involved excessive amount of administrative overhead.

The study team interviewed HEW officials along with personnel from State mental health agencies, the National Advisory Mental Health Council, CMHCs, the National Council of Community Mental Health Centers, the American Psychiatric Association, and OMB. In addition, all relevant management documents were reviewed.

The 1975 report, "The Community Mental Health Centers Staffing Grant Program of HEW," concluded that evidence indicated a need for considerable improvement on the part of HEW in administering the CMHC program.

Specifically, HEW should (1) improve its organizational responsiveness to the CMHC program; (2) place increased emphasis on the development of effective procedures, standards, criteria, and regulations to ensure the approval, funding, and maintenance of quality projects; (3) enhance the effectiveness of the grantee monitoring; (4) provide for more timely and systematic technical assistance to CMHC grantees and States; and (5) ensure greater accountability for Federal funds expended through more effective evaluations of CMHC activities and increased reliance on programmatic and fiscal audits/reviews of CMHC grantees.

Each of these areas has been the subject of considerable emphasis by NIMH. A similar study today would find substantial improvement.

Age Discrimination Study Report

The Congress, in preparation for the implementation of the Age Discrimination Act of 1975, commissioned the U.S. Commission on Civil Rights to conduct a study of age discrimination in federally funded programs and activities, including the CMHC program. Specific attention was focused on the justification for administratively imposed age distinctions and on any age-based differentials in program participation. Evidence was assembled through staff studies and public hearings. A number of inequities were identified by the Commission:

Only 4 percent of the caseload of CMHCs is made up of elderly clients, despite the fact that 25 percent of persons over 64 have significant mental health problems.

The percentage of elderly seen is lower than the percentage of elderly in the catchment area.

Even though the CMHC Act mandates programs of specialized services to the elderly and to children, CMHCs to date do not seem to serve these groups adequately.

Centers offer various reasons (expense, cost-inefficiency and lack of adequately trained personnel) for not serving or serving inadequately older and younger persons in need of mental health care.

Needs assessment activities carried out by CMHCs and State mental health authorities do not influence resource allocations or program development decisions.

There is currently a lack of outreach by centers and negative staff attitudes in treating the elderly and children.

The relationship between Medicare/Medicaid and CMHCs does not contain incentives to provide for services to older persons.

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In response to these findings, various activities have been undertaken by program staff. Specific attention is being placed on the development of better CMHC outreach to the elderly and children through other health care providers, the social service systems, assorted self-help and golden age groups and nursing homes.

In an attempt to increase staff sensitivity to the quantity of services available to the elderly and children, efforts have been and continue to be pursued in grant applications reviews, monitoring and technical assistance to try to decrease the fear which the elderly and children often feel about psychiatric treatment.

Further attention is being given in mental health training programs to support geriatric training. To address the inequities of financial reimbursement for psychiatric treatment of the elderly, a demonstration project is under way to explore provider status for CMHCs.

The Community Mental Health Centers Amendments of 1975 (PL 94–63) provided further impetus for CMHCs to provide services to the elderly and children by requiring programs of specialized services for these groups.

Since 1975 centers have been providing more services to the elderly. Approximately 75 percent of conversion grantees have added programs for the elderly.

ABT Study

The CMHC Program has incorporated the seed money concept since 1965 when Public Law 89–105 was enacted to provide staffing grant assistance. The concept was based on the notion that Federal financial assistance would provide the necessary funding impetus to begin CMHC services and that over a time other sources of support would be found as the amount of the Federal staffing grant declined and Federal funds were eventually terminated.

Although there has been concern with the status of graduate CMHCs, i.e., those having terminated all Federal support for operations, it was not until FY 1976 that there was a sufficient number of CMHCs in this category to make it possible to study them as a group.

In order to help fulfill this gap a contract (HEW–100–76–0205) was given to ABT Associates, Inc. for a study entitled "Community Mental Health Centers—A Decade Later."

The study was undertaken to determine (1) if CMHCs are able to obtain funds from other sources to replace Federal grant funds and (2) if the structure and services of CMHCs are affected by the termination of Federal CMHC grants. The study included (1) a statistical analysis of data, gathered in the fifth and eighth year of operation, for all 99 centers which had been operating for 10 years or more and are thus beyond the initial eight-year funding period, and (2) an in-depth study of 28 sample centers.

The findings were that by the end of the eight-year funding period, centers become financially resourceful without compromising the CHMC philosophy. However, by the tenth year of operation, centers began to submit to fiscal constraints and external forces which in turn caused changes in service priorities and potentially in client mix.

Between the fifth and eight years of the staffing grants centers were able to obtain third-party revenues and patient fees which substituted

for the declining amounts of the grant. After the eighth year and termination of the Federal grant, third-party revenues stabilized in growth while State and local funds become more crucial to the replacement of lost Federal funds. Such State and local funds often come with service requirements and priorities which conflict with Federal CMHC objectives. Consultation and education services and satellite clinics are significantly diminished, and there is a shift away from outpatient services with attendant increases in the use of profitable inpatient services.

2. The President's Commission on Mental Health

President Carter established the Commission by Executive Order No. 11973 on February 17, 1977, to review the mental health needs of our nation and make recommendations as to how best to meet these needs.

The Commission was composed of 20 distinguished citizens. The majority of the Commission was composed of concerned lay persons.

The Commission gathered information for one year from hundreds of individuals by holding public hearings around the country. Individuals providing such information included highly trained professionals, volunteers who work in local programs, former patients, State and local officials, representatives from self-help groups and others. The Commission also asked the 50 Governors and each member of Congress for suggestions and ideas.

Ms Rosalynn Carter was the Commission's honorary chairperson.

The Commission presented its report to the President in April of 1978. Following are its major findings:

> Great progress has been made in reaching and treating the mentally ill, but serious deficiencies still exist. There are millions of Americans who remain unserved, underserved, or inappropriately served by the present mental health care system. Far too many Americans do not have access to mental health services because of where they live or financial barriers.
>
> The population of large mental institutions declined from approximately 600,000 to about 160,000 between 1955 and the present. In 1955, three out of four persons were treated as inpatients, whereas now three out of four persons receiving mental health care are treated as outpatients. Nevertheless, State hospitals continue to provide a major portion of long-term care for those with chronic mental illness.
>
> For many years, deinstitutionalization has meant being "dumped" into a community, to live in an inadequate boarding home or single room occupancy hotel. Former mental hospital patients were, thus, left without adequate food, clothing, recreation or social services.
>
> Today, stable community living has been made available to 1.5 million adults with chronic mental disabilities. This is possible only if former patients have access to both mental health care and support services such as housing, vocational rehabilitation, training in community living skills, day care, medical care and income maintenance.

But for many deinstitutionalized patients, "dumping" still occurs—needed mental health and related services are not provided. Because

of the shift from institutional care to widely scattered community based services, mental health services planning and management has increased in complexity. The capacity to effectively plan and manage community based services differs with each State.

The Commission found that our current efforts to prevent mental illness and promote mental health are "unstructured, unfocused, and uncoordinated." Our present system is still in a state of evolution. Established lines of responsibility or accountability have not been adequately established.

The Commission recognized the significant role that the CMHC Act has played in helping to provide mental health care to millions of Americans:

Since the passage of the CMHC Act in 1963, approximately 76 centers have been funded and 111 million people or 50% of the U.S. population live within catchment areas served by these centers.

In 1979, an estimated 2.4 million people received services at CMHCs.

Other monies have been attracted by the CMHC program—each CMHC's Federal dollar is estimated to generate three dollars from non-Federal sources.

There has been a redistribution of mental health resources so that many areas previously without mental health services now have them. More than 54 percent of patients seen in centers have an average annual family income of less than $5,000, and 37% of Federally supported CMHCs serve rural areas.

The program continues to hold local interest. As of October, 1979, 67 communities have begun community mental health center planning activities based on their own assessment of need.

More than 54 percent of patients seen in centers have an average annual family income of less than $5,000, and

Although the Commission found that the CMHC program had accomplished a great deal, it also found that substantial problems persisted:

Certain populations such as the chronically mentally ill, children and youth, the elderly, racial and ethnic minorities, poor persons and residents of rural areas have not been fully served by the CMHC program. There is a need for quality services to be targeted to these underserved populations.

Poor urban areas, rural areas, and small towns do not have an adequate number of trained mental health personnel.

There are insufficient numbers of trained professionals to treat children, adolescents and the elderly.

There are inadequate numbers of minority professionals.

Many communities do not have sufficient resources to support a comprehensive community mental health center that would provide the 12 services required by the current CMHC Act. Greater flexibility is needed.

CMHCs do not give enough emphasis to prevention.

There is a lack in many communities of effective follow-up, outreach and case management for the residents discharged from State mental hospitals.

There is a lack of coordination between the mental health and general health care sectors. Cooperative working relationships between these two settings are rare.

The Commission made a number of recommendations:

A new Federal grant program for community mental health services should be developed to: (a) encourage the creation of necessary services where none exist; (b) supplement existing services where they are inadequate; and (c) increase flexibility by modifying current requirements that communities have to meet in order to receive Federal support.

Priority in this new mental health grant program should be given to: (a) unserved and underserved areas; (b) services for the chronically mentally ill; (c) services for children, adolescents, and the elderly; and (d) specialized services for racial and ethnic minority populations.

The greater public understanding of mental illness that has occurred in our nation is largely due to community based services provided by CMHCs. Many innovative mental health education and community information programs now exist. In order to assure that the gains of the last 15 years are not lost and to assure their continued availability the Commission recommended limited Federal funding for certain services which centers now provide on a non-reimbursable basis.

The Commission also recommended:

Greater flexibility in delineating catchment area boundaries.

Encouragement of cross catchment area program sharing.

Allowing greater variation in governance and advisory board arrangements so that they properly reflect local circumstances.

Assistance for the members of mental health governance or advisory boards in dealing with problems related to the planning and delivery of mental health care.

To meet the needs of minority populations the Commission recommended:

Mental health service programs should:

(a) Actively involve ethnic and racial minorities in planning and developing services;

(b) Provide culturally relevant services and staff them with bilingual, bicultural personnel; and

(c) Contract with minority community-based organizations for delivery of services.

To reduce the financial barriers the elderly face in obtaining mental health services, the Commission recommended:

Amending current Medicare legislation so that:

(a) Community mental centers and other organized systems of community mental health care be given provider status;

(b) The allowable reimbursement for the outpatient treatment of mental conditions be increased to at least $750 in any calendar year;

(c) The beneficiary coinsurance be reduced from 50 percent to 20 percent to conform to Medicare coinsurance requirements for physical illness;

(d) Coverage for inpatient care of psychiatric disorders in acute care settings be extended so it is equivalent to that provided for physical illness; and

(e) Two days of partial hospitalization be allowed for each day of inpatient care.

3. Rights and Advocacy

Citizens receiving mental health care have the same rights as all other citizens. But they often have profund disadvantages in asserting their own rights or protecting their own interests—disadvantages which stem from their mental condition, from stereotypes conferred by the label of mental illness, or both. This added handicap has led in the past to mistaken assumptions that persons with mental health problems have no rights or that their rights are somehow suspended because of their illnesses.

The abuses of people receiving mental health care have been described and detailed in many reports, court records and Congressional hearings.[8] As the President's Commission on Mental Health concluded: We are keenly aware that even the best intentioned efforts to deliver services to mentally disabled persons have historically resulted in well-documented cases of exploitation and abuse. (Vol. I, P. 42.) Testimony at hearings on this bill document that not only intentional abuse, but simple neglect and disregard of the rights of mentally ill citizens all too often continue. This problem is most frequently noted within large institutions, but it exists in many other agencies and in the community as well.

The President's Commission on Mental Health Task Panel on Legal and Ethical Issues pointed out "that enactment of a bill of rights in no way consigns the mentally handicapped to second-class citizen status. Rather, it is an acknowledgment of the historic fact that such persons have been perceived and treated as second-class citizens—or worse—by, much of society." (Vol. IV, P. 1464.)

The Task Panel on Legal and Ethical Issues concluded:

> Perhaps the most important point that the Panel wishes to convey to the Commission is the importance of building a strong 'patients'-rights' and consumers' perspective into any reforms in the services system. (Vol. IV, P. 1363.)

The Commission made the protection of basic rights a major emphasis of its report to the President:

> The protection of human rights and the guarantee of freedom of choice are among the most basic principles of society.

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[8] *See* President's Commission on Mental Health. *Report to the President,* GPO (April 1978) ; *Report to the Congress: Controls on the Use of Psychotherapeutic Drugs and Improved Psychiatrist Staffing Are Needed in Veterans Administration Hospitals,* Comptroller General Report (M.W.D.–74–47, 1975) ; *Wyatt* v. *Stickney,* 325 F. Supp. 78, 344 F. Supp. 373, 344 F. Supp. 398 (M.D. Ala. 1972), *aff'd sub nom. Wyatt* v. *Aderholt,* 503 F. 2d 1305 (5th Cir. 1974) ; *Dixon* v. *Weinberger,* 405 F. Supp. 974 (D.D.C. 1974) ; *Davis* v. *Watkins,* 384 F. Supp. 1196 (N.D. Ohio 1974) ; Hearings on the Constitutional Rights of the Mentally Ill Before the Subcommittee on Constitutional Rights of the Senate Committee on the Judiciary, 87th Cong. 1st sess. 1 (1961) and 91st Cong., 1st and 2d sess. (1969–70) ; Civil Rights of Institutionalized Persons. Hearings on S. 1393 Before the Subcommittee on the Constitution of the Senate Comm. on the Judiciary, 95th Cong. 1st sess. (1977) ; Civil Rights of Institutionalized Persons, Hearings on H.R. 2439, H.R. 5971 Before the Subcomm. on Courts, Civil Liberties, and the Administration of Justice of the House Comm. on the Judiciary, 95th Cong., 1st sess. (1977) ; Civil Rights of Institutionalized Persons, Hearings on H.R. 10 Before the Subcomm. on Courts, Civil Liberties, and the Administration of Justice of the House Comm. on the Judiciary, 96th Cong., 1st sess. (1979) ; Civil Rights of Institutionalized Persons. Hearings on S. 10 Before the Subcomm. on the Constitution of the Senate Comm. on the Judiciary, 96th Cong., 1st sess. (1979) ; Individual Rights and the Federal Role in Behavioral Modification. Study Prepared by Staff of Subcomm. on Constitutional Rights of the Senate Comm. on the Judiciary, 93d Cong., 2d sess. (1974).

Mental health programs and services must not disregard these values. (Vol. I, P. 42.)

Congress has in the past recognized the need for special protections for the rights of vulnerable people in our society. Title V of the Rehabilitation Act of 1973, 29 U.S.C. 790 *et seq.*, prohibits discrimination on the basis of handicap. The Education for All Handicapped Children Act, 20 U.S.C. §§ 1401 *et seq.*, requires a free, appropriate education for handicapped children in the least restrictive environment. The Older Americans Act, 42 U.S.C. 3001 *et seq.* provides for specialized advocacy assistance to the elderly. The Developmental Disabilities Assistance and Bill of Rights Act, 42 U.S.C. § 6010 *et seq.*, establishes a bill of rights and advocacy system for developmentally disabled citizens. Title III of this bill provides similar protections for citizens receiving mental health care.

4. The Need for a Mental Health Systems Act

Since 1963, millions of mentally ill Americans, who would once have been sent to remote, restrictive State mental hospitals or simply denied treatment altogether, have been provided with mental health care of high quality in their home communities. This enormous progress in caring for those with mental illness is due in large part to the Community Mental Health Center program.

But the very success of the CMHC program has pointed out the weakness of its statutory framework, the Community Mental Health Center Act. Many of those weaknesses could be—and have been—repaired without replacing the Act itself; however, it is now clear that certain fundamental mental health needs in our society cannot be addressed until a new legislative framework is created.

The special needs of those who suffer most and longest from mental illness—the chronically mentally ill—have not been adequately met by the CMHC program. In part this is due to resource limitations. The needs of chronically mentally ill individuals are often so great that properly providing them with treatment and care would make it extremely difficult for CMHC's to effectively serve other groups or carry out their other important missions. Additionally, the chronically mentally ill are often less able to compete with other more articulate and demanding groups for scarce CMHC resources. In order to respond to the enormous pressing needs of the chronically mentally ill, a departure from the exclusive reliance on CMHC's—and thus a departure from the Community Mental Health Centers Act itself—is necessary.

The unique mental health problems faced by children and youth, the elderly, racial and ethnic minorities, women, and others can also no longer be met simply by amending the Community Mental Health Centers Act. In some communities, where a comprehensive CMHC may not be needed or be a priority, there may nonetheless be an urgent need to provide mental health care to one or more of these particularly vulnerable groups. The Community Mental Health Centers Act does not provide a vehicle for such a non-comprehensive approach; therefore, a more flexible statutory framework is required.

The need to reconcile, to link, to unify the role of the States—which continue to provide the majority of public mental health resources in this country—and the role of the Federal government can also not be

met by simply amending the existing law. Existing law does not provide an adequate role for the States, and Federal funding decisions have often been made without adequate consultation with the States. States were often expected to pick up the continuation costs of CMHCs, but they did not play much of a role in deciding whether, and where, CMHCs should be established.

In 1963, when many States were still opposed or uncommitted to community-based care, this policy was clearly justified. But in 1980, things are different. States are now generally committed to community-based care. They have become the main financial supporters for graduating CMHCs. Yet the integration of the State role and the Federal role with regard to their common promotion of community-based mental health care has not taken place. It cannot take place as long as the Community Mental Health Centers Act remains the sole instrument of Federal mental health policy.

Today, local private nonprofit groups, local governments, State government, and the Federal government are part of a chaotic, inefficient, and wasteful mental health system. It is, in fact, a mental health non-system. Now that State governments and the Federal government share a commitment to community-based mental health care, this non-system is no longer acceptable. To bring about the coherent mental health system our nation requires, a Mental Health Systems Act is necessary.

The need to integrate the overall health planning process with the mental health planning process can not be met by amending the CMHC Act.

The need to protect patients' rights similarly requires more than modification of the CMHC Act.

In sum, the mental health problems the country faces as it moves into the 1980s require solutions which go beyond the purpose and scope of the Community Mental Health Centers Act. A new statutory framework, which focuses on the development of a unified mental health system, is required. Hence, the Mental Health Systems Act.

III. History of S. 1177—The Mental Health Systems Act

INTRODUCTION OF S. 1177

Prior to the introduction of S. 1177, the Mental Health Systems Act, the Senate Subcommittee on Health and Scientific Research held a hearing, on February 7, 1979, to examine the recommendations of the President's Commission on Mental Health. At this hearing, entitled "Reappraisal of Mental Health Policy—1979", Ms. Rosalynn Carter, the Commission's Honorary Chairperson, testified.

On May 17, 1979, S. 1177, was introduced by Senators Kennedy, Williams, Pell, and Javits, and was referred to the Committee on Labor and Human Resources. Subsequently, Senators Schweiker, Randolph, and Cranston were added as co-sponsors.

On May 24, 1979, and June 11, 1979, the Subcommittee on Health and Scientific Research held hearings on S. 1177. The following witnesses testified:

On May 24, 1979:

The Honorable Joseph A. Califano, Jr., Secretary, Department of Health, Education, and Welfare.

Ms. Hilda Robbins, National President, Mental Health Association.

Dr. John Wolfe, Executive Director, National Council of Community Mental Health Centers.

Mr. Robert E. McGarrah, Jr., Assistant Director for Public Policy, American Federation of State, County and Municipal Employees.

Mr. Paul Friedman, Director, Mental Health Law Project.

On June 11, 1979:

Senator Daniel K. Inouye, Senator Spark M. Matsunaga.

Accompanied by:

Dr. Denis Mee Lee, Chief, Division of Mental Health, State of Hawaii.

Dr. Lawrence Koseki, Chairman, Advisory Council on Minority Concerns Alcohol, Drug Abuse, and Mental Health Administration Department of Health, Education, and Welfare.

Dr. Gilbert Tanabe, Professor of Psychology, University of Hawaii.

A panel on the mental health needs of minorities and women:

Dr. James Collins, Chairman, Department of Psychiatry, Howard University School of Medicine.

Mr. Rodolpho Sanchez, National Director, National Coalition of Hispanic Mental Health and Human Services Organizations (COSSMHO).

Mr. Mark Tajima, Washington Coordinator, Pacific Asian Coalition.

Dr. Nancy Felipe Russo, Federation of Organizations for Professional Women, Member of the Sub-Panel on Mental Health of Women of the President's Commission on Mental Health.

A panel on rape research, prevention, and services:

Ms. Ina Lorton, Director, Baltimore County Sexual Assault and Domestic Violence Center.

Dr. Martha Burt, Research Associate, Urban Institute, Washington, D.C.

Dr. Gary Vanden Bos, American Psychological Association, Association for the Advancement of Psychology.

Dr. Lee Macht, Professor and Head of the Department of Psychiatry, Harvard Medical School at Cambridge City Hospital, American Psychiatric Association.

In addition, statements for the record and additional information were submitted by the following organizations and individuals:

STATEMENTS

American Federation of Labor and Congress of Industrial Organizations, Kenneth Young, director, department of legislation.

American Hospital Association.

American Nurses' Association, Inc., Barbara Nichols, president.

American Occupational Therapy Association, Inc., the, Mae D. Hightower, president.

Burt, Dr. Martha R., research associate, the Urban Institute.

Califano, Joseph A., Jr., Secretary of Health, Education, and Welfare.

Collins, Dr. James, chairman, department of psychiatry, Howard University School of Medicine; Rodolfo Sanchez, national executive director, National Coalition of Hispanic Mental Health and Human Services Organizations; Mark Tajima, Washington Coordinator, Pacific Asian Coalition; and Dr. Nancy Felipe Russo, Federation of Organizations for Professional Women and member of the Subpanel on Mental Health of Women of the Presidents Commission on Mental Health.

Friedman, Paul R., director, mental health law project, accompanied by Leslie Scallet, staff attorney.

Inouye, Hon. Daniel K., a U.S. Senator from the State of Hawaii.

Javits, Hon. Jacob K., a U.S. Senator from the State of New York.

Klein, Ann, commissioner, Department of Human Services, State of New Jersey.

Lee, Dr. Denis Mee, chief, division of mental health, State of Hawaii.

Lorton, Ms. Ina, director, Baltimore County Sexual Assault and Domestic Violence Center, and Dr. Martha Burt, research associate, Urban Institute, a panel.

Macht, Lee, M.D., member American Psychiatric Association.

Matsunaga, Hon. Spark M., a U.S. Senator from the State of Hawaii.

McGarrah, Robert E. Jr., assistant director for public policy, American Federation of State, County, and Municipal Employees.

National Association of State Mental Health Program Directors, James A. Prevost, M.D.

National Coalition Against Sexual Assault, Sandra K. Lambert.

O'Bannon, Helen B., secretary, public welfare, Commonwealth of Pennsylvania.

Robbins, Hilda, national president of the Mental Health Association, accompanied by Robert Vandivier, acting program director, National Mental Health Association.

Russo, Nancy Felipe, Ph. D., council member, Federation of Organizations for Professional Women, member, Subpanel on the Mental Health of Women, President's Commission on Mental Health.

Sanchez, Rodolfo B., national executive director of the National Coalition of Hispanic Mental Health and Human Services Organizations (COSSMHO).

Schweiker, Hon. Richard S., a U.S. Senator from the State of Pennsylvania.

Stai, Richard T., chairman, legislative committee, Lansdowne Mental Health Center, Ashland, Ky.

Tajima, Mark, Washington, coordinator, Pacific/Asian Coalition (PAC).

Tanabe, Dr. Gilfred, professor of psychology, University of Hawaii.

VandenBos, Gary, Ph. D., American Psychological Association and Association for the Advancement of Psychology, and Lee Macht, M.D., professor and head of the department of psychiatry, Harvard Medical School at Cambridge City Hospital, and American Psychiatrist Association.

Van Ness, Stanley C., public advocate, Department of the Public Advocate, Trenton, N.J.

Wolfe, John C., Ph. D., executive director, National Council of Community Mental Health Centers, accompanied by Chris Koyanagi, special consultant for government affairs, National Council of Community Mental Health Centers; and David Sandler, attorney at law, director, government relations, National Council of Community Mental Health Centers.

ADDITIONAL INFORMATION

Articles, publications, etc.:

Annual Report for 1977–78 of the minority fellowship program, by Dr. James M. Jones, director (with attachments).

Assurance of accountability.

Employee protections for mental health workers, documents submitted by the American Federation of State, County and Municipal Employees.

Mental Health of Asian/Pacific Americans, report of the Special Populations Subpanel on, February 15, 1978.

Proper staffing of regional offices.

Communications to Kennedy, Hon. Edward M., chairman, Subcommittee on Health and Scientific Research from:

Cutler, Jay B., special counsel and director, division of government relations, American Psychiatric Association, Washington, D.C., July 17, 1979.

Sanchez, Rodolfo B., national executive director, National Coalition of Hispanic Mental Health and Human Services Organizations, Washington, D.C., May 23, 1979.

VandenBos, Gary R., Ph. D., administrative officer, mental health policy, American Psychological Association, Washington, D.C., June 21, 1979.

These hearings focused on the adequacy of S. 1177 in meeting the nation's mental health needs. There was general agreement that there was a need for creative mental health legislation.

Witnesses made the following major objections to S. 1177 as introduced:

The bill failed to make an adequate commitment to the continuation of comprehensive community mental health centers;

The bill, in its effort to restructure the defective mental health system now in place, failed to provide for a truly coherent working relationship among local organizations, local and State governments, and the Federal government;

The bill failed in particular to give the States, which provide far more mental health dollars than the Federal government, an adequate role in determining how Federal resources are spent;

The bill failed to include a patients' bill of rights and advocacy program;

The bill did not adequately address the needs of racial and ethnic minorities with respect to the delivery of mental health services, mental health research, and mental health training.

Several witnesses commented on the need to reauthorize and expand the rape prevention and control programs administered by the National Institute of Mental Health.

The legislation was subsequently considered in open executive session by the Subcommittee on Health and Scientific Research on October 18, 1979, at which time the bill was amended and ordered favorably reported to the Committee on Labor and Human Resources by a vote of 9–0. This bill, with further amendments, was considered in open executive session on April 24, 1980, by the Committee on Labor and Human Resources and ordered favorably reported by a vote of 11–1 to the Senate.

The Administration, the National Council of Community Mental Health Centers, the Mental Health Association, and the National Association of State Mental Health Program Directors supported the substitute amendment to S. 1177 which the Committee on Labor and Human Resources ordered reported on April 24, 1980.

IV. COMMITTEE VIEWS

The Committee believes that mental health care of high quality and reasonable cost should be available to all Americans who require it. Tragically it is not.

The Committee has been generally pleased with the Community Mental Health Center program to date, although, as with any program this size, some problems do exist. It is clear, however, that the program has been successful in creating community alternatives to State inpatient facilities for mental health care. Accordingly, the Committee is committed to the continuation of the existing program and to the expansion of mental health programs in currently unserved or underserved communities.

Despite this progress in providing community based mental health care since the enactment of the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, many persons still receive inadequate or no mental health care. This is especially true of people with chronic mental illness, children, adolescents, and older Americans. Women, racial and ethnic minorities, the urban poor, and migrant and seasonal farmworkers continue to be underserved.

The 1963 legislation called for a "bold new approach" to the treatment of the mentally disabled through the establishment of a network of community mental health centers and a departure from our dependence on State hospitals. Today there are about 700 such centers, serving millions of our citizens.

While this program offered real hope for both creative and humane treatment methods, combining the latest scientific knowledge with the active participation of the community, today far too many of our citizens who are mentally ill still suffer from abandonment, stigma, and an unresponsive society.

The Committee believes that even with the large gains in community mental health services, the national policy of deinstitutionalization has not been effectively implemented. In fact, the Committee finds the plight of the deinstitutionalized patient an affront to us all. Almost daily we hear about patient abuses from California to New York; we also read about it here in our Nation's Capital. In some cases these patients have been discharged to fend for themselves or placed in nursing homes or boarding homes more inadequate than the discharging institution. Painfully we have come to understand that many of the community residences are more concerned about their reimbursement than the patients' need for quality care in a stimulating environment. In addition to having the stigma of mental illness, patients' employment, housing, and other social service needs have been poorly met. In many cases their problem is compounded by a Social Security income system that is not synchronized with their discharge plan. This results in many patients being discharged with no SSI benefits and this often leads to rehospitalization or exposes the patient to those in the community who would exploit their presence. In general, previous legislation has not effectively served this population. The community services program, as outlined in the Committee's bill, begins to focus services and responsibilities. However, the Committee believes that without improvements in titles IV–B, V, X, XII, XVI, XVIII, XIX, and XX of the Social Security Act, the program will not be totally successful.

The Committee's bill provides clearer and better lines of responsibility for providing mental health services at all levels of government. The bill defines and develops a closer partnership between the Federal and State governments and a better working relationship between Federal, State, and local government and community groups. Conflicting and overlapping Federal statutes are rewritten.

This bill also provides additional resources to care for the deinstitutionalized patient. Past policies of simply moving people "out of their beds and onto the streets" can no longer be tolerated.

The President's Commission on Mental Health appropriately focused on the need to develop informed and aggressive systems of advocacy for mentally ill individuals. This highly vulnerable population is often least able to protect itself against encroachment in the area of their civil rights. Congress recently enacted advocacy programs on behalf of elderly individuals and developmentally disabled individuals. The bill does the same for the mentally ill individuals.

The Committee noted that the report of the President's Commission On Mental Health clearly documents that to date we have done a poor job of responding to the mental health needs of minorities. Persons are much more receptive to receiving services when those services are delivered by individuals who share the unique perspective, value system, and beliefs of the group being served. In spite of this, less than two percent of the psychiatrists in this country are Black, and the data for other minorities and disciplines are equally appalling. For example, nationwide less than .4 percent of psychologists are Hispanic, less than eight percent of the social workers are Black, and there are only 13 American Indian psychiatrists in the country. Many problems of mental illness are caused or exacerbated by the interaction of man with his environment. When that environment is hostile, there is increased possibility of some emotional defect. This is especially significant for minority group members in this country. The Committee believes that the knowledge base of effective treatment methods for minorities must be increased, as must training opportunities for minorities. The barriers which deprive racial minorities of equal entitlement and choice in securing Federal benefits, housing, jobs, education, health and other services are also familiar obstacles to children, elderly individuals and women. Special attention must be given to the effects of racial, age, and sexual discrimination on individuals, along with assistance in adapting to and coping with discrimination, and methods to eliminate such discrimination. The Committee expects that the newly created position of Associate Director for Minority Concerns will address these issues.

During the hearings held on this bill, the Committee learned that over 65,000 instances of rape are reported in this country each year—and best estimates are that the actual incidence of rape is four times that number. With a population of over 100 million women in this country—and with no change in this rate—the chances are better than one in fifteen that a woman will be a victim of rape sometime during her life. The Committee's bill continues the authorization of Rape Prevention and Control program at the National Institutes of Mental Health.

Title I

Section 101 of the Committee's bill requires that for a State to receive funding under this legislation, the State shall meet the requirements of Title I.

Section 102 of the Committee's bill requires that each State shall designate an agency or authority to act as the State administrative agency with regard to mental health services. The bill requires that this Agency carry out the functions of Sections 103, 104, and 105 of the Committee's bill.

Section 103 of the Committee's bill provides that within one year after the enactment of the legislation each State Agency shall divide the state into, and designate, mental health service areas. The Committee believes that each mental health service area should be a geographic region appropriate for the effective development, delivery, and coordination of mental health services in the area. Prior to designating mental health service areas, the State Agency is expected to con-

duct hearings relating to the designation of such areas, and all interested persons shall be afforded an opportunity to participate in such hearings. In designating mental health service areas, the State Agency should consider the following factors:

(1) The optimum number of persons to be served in each area;
(2) The accessibility of services to persons in each area;
(3) The cultural needs of the area;
(4) Pre-existing geographic boundaries related to the provisions of mental health and other services;
(5) The boundaries of the health service area of the state established pursuant to Title XV of the Public Health Service Act.

The Committee anticipates that the mental health service areas shall be within and conform to the boundaries of the health service areas established pursuant to Title XV of the Public Health Service Act.

The Committee further anticipates that the Secretary may want to define the optimum size for mental health service areas, accessibility and cultural needs, as well as considerations for an adequate public hearing.

Section 104 of the Committee's bill requires that each State health plan prepared pursuant to title XV of the Public Health Service Act shall contain provisions relating to the need for mental health services in the State; the special needs of chronically mentally ill persons, emotionally disturbed children and adolescents, and other priority population groups. The plan shall also address the adequacy of public and private mental health facilities and services available in the State; mental health service priorities; geographic, cultural, linguistic, and economic barriers with respect to the delivery of mental health services in the State; the coordination of mental health services with health and other services; the measures to be taken to assure that criteria, standards, and data collection are in the form prescribed by the Secretary. The bill allows the Secretary to prescribe additional requirements to carry out the provisions of title XV of the Public Health Service Act and this Act.

This approach emphasizes the lead role which state and local planning agencies must play in establishing a comprehensive and integrated series of goals and objectives for health care delivery in order to insure that mental health programs and services are adequately dealt with and are planned for in a more comprehensive way than has been the case in the past. The systems of health planning established by the Congress in Public Law 93–641 and the subsequent amendments, Public Law 96–79, forms the basis for coordinated long-range and annual strategies and implementation programs in mental health, as in all areas of health. The high degree of emphasis given to the specification of mental health goals in this Act and in the amendments of Title XV of the Public Health Service Act reflects the Committee's clear intention to coordinate planning at the state level so that a more unified policy may emerge from the integration to mental health and physical health programs, services, and facilities.

The Committee has given the Secretary some flexibility in carrying out the provisions of Title XV of the Public Health Service Act in order that the integration of mental health and physical health planning may be best achieved.

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The Committee anticipates that the State Health Planning and Development Agency and the State Health Coordinating Council will work closely with the State mental health agency in developing this plan.

Section 105 of the Committee's bill provides that each State Agency shall prepare, consistent with the mental health provisions of the State health plan outlined in Section 104, and after consultation with the Statewide Health Coordinating Council, a mental health operations program. This operations program shall identify the mental health service areas within the State and the mental health service needs of each area after consideration of the demographic, economic, cultural, and social characteristics of the population of the area and the services and activities needed for prevention. The special needs of chronically mentally ill individuals shall be identified along with those of emotionally disturbed children and adolescents, elderly individuals, and other priority population groups. The public and private mental health facilities, personnel, and services available in each mental health service area shall be evaluated with a determination made of additional facilities, personnel, and services necessary to meet the mental health needs of each area. The methods used to determine and evaluate the needs, facilities, personnel, and services of each mental health service area shall be described. The needs of each mental health service area shall be prioritized in the order in which Federal, State and local resources should be used. Measures needing to be taken to alleviate geographic, cultural, linguistic, and economic barriers with respect to the delivery of mental health services are to be identified along with measures taken to assure that mental health services will be provided in a manner respectful of each individual's human dignity and with attention to quality of care. Legal rights of mentally ill individuals shall be described along with any measures to be taken to protect such rights. The Committee expects that this section will be coordinated with the provisions in Title III. Measures to be taken to coordinate the provision of mental health services and support services for chronically mentally ill individuals and other population groups shall be identified.

The operations program shall also describe how the State Agency will ensure the continued provision of appropriate services which have been provided in the past by local entities which received Federal funding under the CMHC Act and this Act, but which may in the future become ineligible for Federal funding under this Act. The operations program shall promote the development of comprehensive mental health services in each service area where such services are currently unavailable and shall ensure within five years after the strategy is prepared (or within such other period as the State Agency justifies and the Secretary determines to be reasonable) that residents of public inpatient psychiatric facilities who are inappropriately placed in such facilities, and that persons who need to be placed in mental health facilities, are identified. The State Agency shall ensure that those who are inappropriately placed are discharged and that all persons who need mental health and support services are provided such services in the least restrictive setting apropriate to each person's level of functioning. Persons who are discharged from, or are in need of

placement in, mental health facilities shall before discharge or prior to placement be informed of available community based facilities and programs providing mental health and related support services, and have access to a sufficient number of adequately staffed and funded community-based facilities and programs providing mental health and related support services.

The operations program shall promote the development of adequate mental health services for chronically mentally ill individuals and other priority population groups, the prevention of mental illness, and assist the courts and other public agencies, and appropriate private agencies, in screening persons being considered for inpatient care. Programs developed under this section of the bill must comply with regulations prescribed by the Secretary of Labor pursuant to section 212(b) of the bill which requires the States to identify and evaluate public and private mental health facilities and mental health personnel and mental health services in each area. This is intended to obligate the States to account for the current personnel resources in both institutional and community-based services. The Committee intends to have each State fully implement these provisions which require employee protections and intends that personnel resources will be fully described in a manner that will facilitate the maximum use of State mental hospital workers in both institutional and community-based services. The Committee believes that a transition of personnel from institutions to the community is absolutely vital if States are to adequately assess their manpower needs.

The provisions of this section of the Committee's bill envision a substantial commitment by the states to deinstitutionalization. At the same time, however, the Committee believes the Secretary of Health and Human Services and the Secretary of Labor must cooperate in exerting maximum influence on the States to assure a relocation and protective arrangement for employees affected by deinstitutionalization. This is consistent with the purposes of the Act, and it is the Committee's intent that deinstitutionalization be accompanied by adequate protections for both patients and employees.

The operation program shall describe the financial commitment and ability of the State to implement the program and shall include an analysis of the services made available for mentally ill individuals in the State under titles IV, V, XVI, XVIII, XIX, and XX of the Social Security Act, the Education for All Handicapped Children Act, the Older Americans Act, the Developmental Disabilities Assistance and Bill of Rights Act, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1973, the Drug Abuse Office and Treatment Act, and other relevant Federal statutes, and describe steps being taken to coordinate the provision of services under these Acts.

In preparing the mental health operations program, the State Agency shall consult with a State advisory council which shall include representatives of consumers, providers, and representatives of nongovernmental organizations and State Agencies concerned with the planning, operation, or use of such services. Consumers shall constitute a majority of the members of the council. The Committee strongly emphasizes that funds under this legislation shall not be expended for these advisory councils.

The Committee intends that the operation program, while separate and distinct from the state health plan and its identifiable mental health goals, objectives, strategies and prescribed activities, should follow and be consistent with the policies, strategies and goals addressed in the state health plan described in Section 104. In addition the operations program will serve administrative and implementation functions for the state mental health agency. As such it permits the Secretary to assess compliance with specific requirements of the Mental Health Systems Act identified in this section.

The Committee does not intend that the operations program be used as a way of perpetuating a separate and isolated approach to goals and objectives planning in the mental health area. For this reason the Committee has specifically required consultation with the Statewide Health Coordinating Council (SHCC) so that the goals and objectives of Title XV of the Public Health Service Act, where they address mental health issues, will be coordinated with the mental health operations program and a consistent and coherent set of documents at both the planning and operations level may be produced without needless duplication.

Section 106 of the Committee's bill provides an enforcement mechanism and provides that whenever the Secretary determines that there has been a substantial and persistent failure to comply with the requirements of this Title, the Secretary shall notify the State Agency that further payments under the Act will not be made to any entity in the State, including the State Agency, until the Secretary is satisfied that such failure has been or will be corrected. However, funding may continue to entities other than the State Agency funded under the CMHC Act prior to October 1, 1979, if the entity did not contribute to the failure to comply. This provision was added to assure continued funding to existing CMHC's when, through no fault of the centers, the State fails to comply with the provisions in this section. The Federal government's obligation to continue payments to such affected CMHCs shall continue until the obligation is fulfilled as long as the CMHCs continue in compliance with the applicable provisions of the CMHC Act.

Title II

Section 201 of the Committee's bill authorizes the Secretary to enter into contracts to accomplish the objectives of this Title.

Section 202(a) of the Committee's bill authorizes the Secretary to enter into contracts with public or private entities other than State Agencies for development of mental health and related support services to chronically mentally ill individuals. The intent of this section is to provide Federal stimulation and assistance for developing comprehensive community support systems to meet the needs and develop the potential of this population in the least restrictive setting possible.

Local applicants for contracts under Sec. 202(a) may include but need not necessarily be limited to municipal or county mental health agencies, community mental health centers, non-profit voluntary agencies such as transitional services corporations, psychosocial rehabilitation centers, family services agencies, and other agencies in a position to promote development and improvement of community support serv-

ices for individuals with chronic mental illness. The Committee does not intend that these funds be awarded to inpatient facilities.

Contracts under this subsection must provide for at least one of several functions. These functions include: (1) identifying the target population by providing outreach to hospital and community settings, identifying barriers to appropriate services, and developing measures to eliminate or overcome such barriers; (2) developing case management services to coordinate mental health with related support services for the target population and assuring availability of outreach services to families and employers of people with chronic mental illness; (3) collaborating with other mental health, health and human services agencies to develop community support services not otherwise available to the population.

The services to be developed through this sub-section include, but need not necessarily be limited to: screening and referral, follow-up care, alternatives to hospitalization, assistance in applying for entitlements, crisis stabilization, psychosocial rehabilitation, and supportive living and working arrangements. The intention is to use the resources available under this section to promote development of a comprehensive network of appropriate services for chronically mentally ill persons at the local level, relying on broader State funding and "mainstream" human service program funding to the greatest extent possible for basic health services, income maintenance, housing, vocational rehabilitation, social and employment services. The Committee intends that the money available under this sub-section should be regarded as "last dollar" money, and should *not* be used for direct funding of generic services such as vocational rehabilitation or supportive housing arrangements *unless* no other resources are available.

Priority for funding under this section will be given to agencies that have demonstrated a commitment to serving the chronically mentally ill in a comprehensive way, and to developing effective linkages with other health, mental health and human services agencies. The funds are intended to assist in building local service systems that seek to meet the comprehensive needs of individuals with chronic mental illness on an area-wide basis, in accord with a systematic interagency plan for community support services.

The Committee strongly believes that funds under this section may *not* be used to cover the costs of providing basic CMHC services which all Federally funded CMHC must provide to the chronically mentally ill. In cases where the applicant is a Federally funded CMHC that is currently receiving support under another sub-section of this Act, funding under this sub-section should be used to *supplement* the essential CMHC services to people with chronic mental illness by developing community support services. However, in areas without a Federally funded CMHC, this section may be used for basic mental health services for the chronically mentally ill (such as followup care, crisis stabilization and emergency services) in addition to community support services.

Section 202(b) of the Committee's bill authorizes the Secretary to enter into contracts with State mental health agencies for development of mental health and related support services to chronically mentally ill adults. The intent of this Section is to provide Federal

stimulation and assistance to such agencies in developing comprehensive community support systems throughout the State to meet the needs and develop the potential of chronically mentally disabled individuals in the least restrictive setting possible.

Contracts under this sub-section must provide for at least *one* of several activities, and may include several of the following:

(1) Working with local mental health agencies, municipal or county mental health agencies, sub-state mental health planning bodies, CMHCs, or other such entities to identify chronically mentally ill individuals in need of community support services, and developing and implementing strategies to provide such services. This may involve, for example, contracts for projects to plan and implement comprehensive community support systems with identified geographic areas within the State. The size of the area(s) to be covered, or the numbers of geographic areas for which a State may apply for funding under this sub-section, will vary from State to State. The essential purpose of this activity is to develop integrated local service systems that meet the comprehensive needs of individuals with chronic mental illness—not only their mental health service needs. The local system building process funded under this section, therefore, must of necessity involve a broad range of health, housing, vocational rehabilitation, employment and other human services agencies collaborating with mental health agencies.

(2) Assessing needs of chronically mentally ill individuals throughout the State, and identifying and devising means to overcome local, State and Federal barriers to provision of needed services. This may involve activities similar to those that were previously supported through the Community Support Program's State Community Support System Strategy Development projects. Federal financial assistance may be used for the cost of Statewide needs assessment, participatory planning involving local agencies, consumers and providers and a broad range of State and local human services agencies, and interagency strategy development to meet the needs of individuals with chronic mental illness. The Committee intends that priority for funding these activities will be given to States that did not have the opportunity to participate in the pilot phase of the Community Support Program.

(3) Improving the skills of personnel providing services to chronically mentally ill individuals by providing or arranging for the provision of inservice training, other training, or retraining for such persons. The intent of funding under this section is to help States identify training needs specific to serving people with chronic mental illness, and to promote development of appropriate training programs in collaboration with other agencies. Where possible, identification of training needs should be done by the State Manpower Development Unit, and the direct costs of training should be supported from funding sources intended for training. The Committee encourages the Secretary of Health and Human Services to make full use of this grant authority to train and retrain employees of in-patient psychiatric

facilities. The Committee is concerned that this has not been the case in the past, and reiterates its belief that much greater attention to the issue of training and retraining is necessary before adequate deinstitutionalization efforts can take place. Funding under this subsection for training should be limited to those planning and training activities that cannot be supported through other sources, and that will lead to substantial improvements in the quality and appropriateness of community services to adults with chronic mental illness.

(4) Providing or arranging for provision of job placement for, and training and retraining of employees of public inpatient psychiatric facilities at which there has been a reduction in the need for such employees, in order to train and place such employees in settings where such employees can perform comparable work. This may include Federal financial assistance for State mental health agency staff charged with the responsibility of working with other agencies in the State to assure development of appropriate employment opportunities for employees of public mental hospitals that are being phased down. Where possible, the direct costs of retraining or job placement programs should be covered by funds intended primarily for training or job placement, and not from the funding under this subsection. This subsection may be used to provide limited funds to identify training and retraining needs of hospital employees or to identify employment problems, employment opportunities, and to work with State or Federal agencies in a position to address these problems.

(5) Coordinating the operations of State agencies or intrastate regional agencies responsible for mental health and related support services for chronically mentally ill individuals. Funding of these functions may include the costs of State mental health agency employees at the State or local level who have a system building and coordinating function focusing on individuals with chronic mental illness. For example, a State mental health agency may seek Federal support to establish a State level unit focusing on development of community support systems, and/or deploy staff at sub-state levels charged with similar responsibilities. The functions of these staff should be directed toward upgrading the quality, appropriateness and comprehensiveness of community-based services for individuals with chronic mental illness, and toward maximizing effective use of the various titles of the Social Security Act, the Rehabilitation Act, the United States Housing Act, the Comprehensive Employment and Training Act, the Development Disabilities Assistance and Bill of Rights Act, the Older Americans Act, and other Federal and State statutes, for these purposes. State mental health agencies may apply under this subsection for funding to test out alternative approaches to organization and coordination of services at the local level.

Priority in funding will be given to those States that demonstrate maximally effective use of currently available State resources to perform these activities. Federal funds may not supplement State funds in support of any of these functions.

Section 203 of the Committee's bill provides the authority for the provision of services to severely disturbed children and adolescents.

Approximately two million children and youth suffer severe mental disturbances which, when combined with medical, educational, social and family problems, impede their growth and development. These most severely disturbed young people need a broad array of services such as clinical (psychiatric, psychological, medical), educational, social, recreational and rehabilitative services. The services in most American communities for these young people are both fragmented and insufficient.

The President's Commission on Mental Health recognized the unmet needs of this population. In calling for a new mental health service system with special attention to the underserved and unserved, they specifically called attention to the special needs of children and youth. The DHEW Task Force on implementation of the President's Commission Report recommended legislative authority with the objective of *coordinating and improving the quality and availability of the array of services* for severely emotionally disturbed children and adolescents.

The necessary services and the available sources of funding for children and youth are most often different than those for other populations. A major objective of this section is to recognize the need for the provision of the services necessary to enhance the functioning of these children and their families and to decrease the likelihood that these severely disturbed children and adolescents will develop into chronically mentally ill adults. This includes efforts to create service systems which will coordinate existing services and fill the gaps between them.

The Committee intends that awards under the authority provided by this section would be to support service systems by funding projects in one or more of two basic types of activities. The first type of activity is directed toward improving the system of services already existing in a community. These services provide or have the potential of providing help to children and adolescents who have serious problems. The "systems change" that would be supported is change in the way in which the agencies providing services interact with each other and with the youngsters and their families.

Subsection (1) provides funds for the identification and assessment of the needs of disturbed children and adolescents (and further provides for needed services not provided). This subsection recognizes that communities must analyze the unique character of its population of severely disturbed children and adolescents and plan for needed services, both existing and new.

Subsection (3) provides funds for projects that coordinate the provision of mental health and related support services available to severely disturbed children and adolescents with activities of community agencies and State agencies and with the provision of services available pursuant to titles IV(b), V, XVI, XIX, and XX of the Social Security Act, the Education for All Handicapped Children Act, the Developmental Disabilities Assistance and Bill of Rights Act, the Rehabilitation Act of 1973, and other Federal and State statutes. Funding under this subsection is based on the basic principle that the

broad range of services required by this population is often available in communities with funding available from a number of State and Federal programs. The failure of these existing resources to meet the needs of the community is often the result of inadequate coordination. Projects funded under this subsection will create community systems which assure that children and adolescents receive all the service that will help alleviate their emotional disorders.

Subsection (4) establishes cooperative arrangements with juvenile justice authorities, educational authorities, and other authorities and agencies that come in contact with severely disturbed children and adolescents to appropriate mental health and related support services. A logical step beyond coordination or as an aid to coordination is to provide support which actively links agencies which must work closely to meet the needs of severely disturbed children and adolescents. The cooperative agreements funded under this subsection will not only assure proper referral to mental health agencies but will also elucidate the interrelationships between the involved agencies.

The second type of activity authorized in this section is directed toward filling gaps in services for severely disturbed children and adolescents. In communities where the system itself is satisfactory, i.e., human service agencies are interacting in a manner conducive to serving severely disturbed youth well, it is possible to identify real gaps in services—gaps that cannot be filled simply by changing the manner in which existing services are provided or interact with one another. In such instances, it is possible to conduct and support an assessment of unmet needs and to then develop the services needed to fill in the gap. The Act would pay for personnel to provide those services, once developed, and/or for personnel to act as referral agents or case managers.

Subsection (1) also provides for needed services which are not provided by existing programs. As mentioned before, the provision of these services is linked to the filling of service gaps identified in a community needs assessment. The wide range of service needs and limited funding available requires that duplication of services be avoided and that direct service programs be established only when their need is well documented and where the need cannot be met through coordination and system development. Once the needs are documented, lacking mental health components can be funded under this section.

Subsection (2) assures the availability of appropriate personnel responsible for providing, or arranging for the provision of, mental health and related support services needed by severely disturbed children and adolescents. The support of adequate services requires the availability of appropriately trained personnel. This subsection funds staffing of service components of existing programs, new programs, and coordination of services. It should be reemphasized that the funding is available only where gaps in services are identified.

The Act specifically mentions three distinct kinds of services whose *establishment* can be supported under this Act—self-help groups, crisis support programs (Subsection (5)), auxiliary mental health services to children identified as needing such services under the Education for All Handicapped Children Act (Subsection (6)). These

special areas of service need are targeted because of recent recognition that self-help groups and crisis support programs have shown much promise and that the linkages between educational and mental health systems are imperative under P.L. 94–142. The Committee believes that the funding under this important section be consistent with community development of systems of comprehensive mental health service delivery.

Section 204 of the Committee's bill is intended to provide mental health services for elderly individuals.

The principal mandate under this section is the assurance of mental health and support service to elderly individuals. Under this section, the Secretary will enter into contracts with public and nonprofit private entities for outreach services and at least one other mental health or related support service needed by the elderly.

The Committee was disturbed that the Administration did not include services to the elderly in S. 1177 as introduced, and added the provisions of this section in subcommittee.

The Committee found page 31 of the report of the President's Commission on Mental Health particularly compelling:

> The 23 million Americans over the age of sixty-five—one-third of whom are below the official poverty line—constitute another large segment of the population underserved by our current mental health care system.
>
> The prevalence of mental illness and emotional distress is higher among those over age sixty-five than in the general population. Up to 25 percent of older persons have been estimated to have significant mental health problems. Yet only 4 percent of patients seen in public outpatient mental health clinics and 2 percent of those seen in private psychiatric care are elderly.
>
> Part of the problem is attitudinal. Too often the elderly are told, and many believe, that adverse psychological symptoms are natural aspects of growing old. Senility is a term loosely applied to thousands of older Americans, yet as many as 20 to 30 percent of those so labeled have specific conditions that can be diagnosed, treated, and often reversed.
>
> The elderly are subjected to multiple psychological stresses brought about by such things as social isolation, grief over loss of loved ones, and fears of illness and death. Yet there are almost no outreach efforts or in-home services in existing mental health programs to bring them into contact with the kinds of services they need. The personnel who are available to help them are often inadequately trained to address their special concerns. Instead, we confine our older citizens to nursing homes where good mental health care is seldom available.

The problem of accessibility to needed mental health services can be ameliorated through outreach activities. These activities are vital and are the foundation upon which services to the elderly within their communities must be based. In addition, a contract under this section may provide for identifying and assessing the mental health needs

of elderly individuals and providing services where gaps exist, assuring the availability of personnel to provide or arrange for mental health and support services, and cordinating existing services and programs available for the mentally ill elderly. The Committee is sensitive to the fact that older people in institutions have very different characteristics from the total elderly population. About 60 percent of them have some degree of senile dementia and an additional 17 percent have either functional mental disorders or retardation. Those conditions coexist with multiple physical diagnoses such as heart disease, stroke, arthritis, and digestive disorders. In recognition of these circumtances, grants under this title may also be used to provide mental health services to elderly individuals in and staff training for employees of nursing homes and intermediate care facilities. Furthermore, staff training for employees of and mental health service linkage with senior centers, boarding homes and other settings in which at-risk groups of elderly individuals gather would be beneficial. Finally, the Committee calls special attention to this section's last suggested use of funds: the medical differential diagnosis. The aged brain is particularly vulnerable to disorders occuring anywhere in the body. Almost any disorder—cardiac, pulmonary, amenia, infection, nutritional deficiency—may produce dementia and delirium symptomatic to mental illness but nevertheless rooted in a physical condition which is treatable. In the Committee's estimation, the medical differential diagnosis is an effective screen to prevent mistreatment of an underlying physical problem and to identify physical disorders which could prove fatal.

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Section 205 provides funds for services for priority population groups. An underlying theme of the Community Mental Health Centers Program has always been to ensure the availability of mental health services to all residents of the catchment area. In addition, the

CMHCs were encouraged to exert a special effort to reach underserved portions of the populations through outreach, targeting and other means. Also in addition, community mental health centers service programs and treatment modalities should, at a minimum, be planned and implemented in such fashion as to ensure an accessible, acceptable and appropriately responsive system of service to minority catchment area residents.

The CMHC should implement programs, policies, and procedures which assure that citizen participatory input is reflected in program planning, and that all board members and staff give specific attention to the identification and elimination of practices which impede the delivery of effective and equitable services to minorities.

To date, approxmately 763 community mental health centers have been funded in the United States, bringing to a peak what some hoped would be a "revolution" in mental health service delivery. The literature on mental health documents the success of community based mental health programs and their impact in service accessibility.

However, despite its mandate and significant success, there is increasing evidence that the CMHC movement has not reached a large segment of the population. The literature on Latino, Black, Asian, and Native American mental health is growing and almost without exception it indicates that mental health services for minority populations are either inaccessible or unresponsive. The President's Commission on Mental Health Report points out that despite major gains in service accessibility over the past 15 years due to the Community Mental Health Centers (CMHC) Program, major gaps continue to exist for high risk, high need groups such as children and youth, women, the elderly, the chronic mental patient, minorities, and victims of disaster.

In order to make our community-based mental health service system more responsive to the needs of priority populations, Section 205 of this Bill expands and complements the existing CMHC system by providing assistance to communities (not yet able to develop all the core services required for a CMHC) to initiate vitally needed services which are designed to meet the unique needs of special population groups. Special attention under this section will be given to providing targeted services to priority population groups and areas with limited mental health services. A contractor under this section will be allowed to initiate a program of comprehensive community mental health services designed to meet the unique needs of a priority population group with fewer than the required number of core services, provided the contractor assures that additional services will be available through affiliation agreements or program expansion.

Section 206 of the Committee's bill provided funds for the prevention of mental illness and the promotion of mental health.

The intent of this section is to stimulate and assist States and local programs to become more sensitive to the importance of and opportunities for maximizing the preventive implications of mental health services programming.

This will be carried out through assistance to States for planning and strategy development, and in turn State collaboration with community programs to assess local needs and potential, and implement those techniques and activities that are appropriate.

This section will also provide funds for demonstration projects to support the development of a wide range of preventive services in communities. These funds would stimulate the development of innovative demonstration projects aimed at evolving specific program models for service delivery at the local level primarily directed at underserved, high risk groups.

Emphasis would be on developing highly specific models of service delivery at the local level in areas of emotional dysfunction which have been identified as most likely to have specific impact. Each project shall specify the intervention techniques and activities to be undertaken, define precisely the target groups to be served, and include an evaluation component to assess the effectiveness of the efforts performed.

Highest priority shall be placed on projects directed to population groups at greatest risk for mental health problems and to those activities which foster the creation of linkages with existing community agencies which may serve such target groups.

Section 207 of the Committee's bill provides support for new and continuing community mental health centers.

The purpose of this section is to fund public and non-profit entities that will provide a comprehensive range of mental health services to the residents of a mental health service area. This entity will continue to be known as a community mental health center as it has since 1963. In addition to providing 12 services (inpatient, emergency, outpatient, assistance to courts and other public agencies, follow-up care, consultation-education, day care and other partial hospitalization services, services to children and the elderly, transitional half-way house services, and alcoholism and alcohol abuse, and drug addiction and abuse services), there must be special attention to peer review in order to provide for quality assurance; an integrated record keeping system that adheres to Federal and State laws concerning confidentiality and access to records; a professional advisory board to advise the board; an identifiable administrative unit that will provide consultation-education services. Care will be given by the CMHC in coordinating services and those health, mental health, and social services provided by other entities in the mental health service area.

The required services may be provided by the CMHC or a satellite facility located in the mental health services area or by the CMHC staff or appropriate staff through special arrangements with other providers in order to provide maximum flexibility and accessibility. Addressing further the issue of flexibility, inpatient, emergency, and partial hospitalization services and certain specialized services such as those for children and the elderly, these may be provided by professionals and agencies in any location that is accessible to the residents of the mental health services area. In such cases, appropriate arrangements must be made to assure prompt and accessible services.

This section continues a model of comprehensive mental health services that has a long record of providing services in an effective fashion. The philosophy of community services along with those concepts of comprehensiveness, continuity of care, accessibility, and a given geographic service area are all maintained while allowing a degree of flexibility not before possible.

Sections 208 of the Committee's bill provides funding for non-revenue producing services.

While some clinical or treatment services provided by a community mental health center are offered on a fee-for-service basis, there are some necessary programs that typically generate limited and, in some cases, no income. For example while consultation and education programs have some revenue producing potential they do not create income from third-party sources. Other necessary activities that are vital to the operation of a community mental health center are evaluation of services in order to determine impact and cost; case management for the purpose of assuring and coordinating those services deemed important for the welfare of a client and other services which are non-revenue producing and have been determined to be appropriate by the Secretary. An example of the latter might be a transportation system devised for the benefit of patients who do not have access to public transportation or cannot afford to pay the high cost of public transportation.

Support for non-revenue producing services is via a contract with public and non-profit private entities providing mental health services. Such services may be offered to a mental health service area by an existing community mental health center or, if one is not available, by an entity providing a full range of comprehensive services.

Because there are no limits set by the legislation regarding the amount of each award per entity and the number of such awards an entity may receive, the Secretary will need to address these two issues in regulations. Further, only those entities providing comprehensive mental health services may be eligible for a non-revenue producing services award and this too must be stated in regulations.

Section 209 of the Committee's bill provides funds for linkages between health care settings and mental health services.

A major goal of this Act is the enhancement of community resources to better meet the needs of individuals with psychiatric problems. This section authorizing linkage with health care facilities in the community, including extended care facilities, is intended to assist the provision of services which are necessary to support the maintenance of all individuals in the least restrictive setting possible.

Linkages with health care facilities, especially primary health care projects assisted under Part D, Subpart I, II, and IV of the PHS Act, and Indian Health Service programs have been demonstrated to be effective in helping to meet the health, mental health, and substance abuse service needs of individuals in communities. The Committee hopes that the promising initiatives which have begun with these other health facilities will be continued and expanded.

In addition, the committee hopes that creative arrangements will be devised to utilize other community resources to improve the quality, accessibility, efficiency, and acceptability of services to persons who utilize mental health services. It is anticipated that in addition to those facilities and programs listed above, linkages will be established with public health departments, hospitals, and long term care facilities to expedite health, social service, substance abuse, and mental health services as they are needed. It is anticipated that case management for continuous and comprehensive care will be provided through a

CMHC or a community primary health care provider, as appropriate. Two way communications and transfers of patients and records (with suitable privacy safeguards) should be enhanced through linkages.

Implicit in this section is the committee's understanding that "health" is used in the broadest possible sense. The meaning of this term encompasses all of the factors which affect health status. It is clearly the committee's intention by this section to authorize assistance of linkages between mental health services and agencies which provide housing, employment, education, training, rehabilitation, social services, or other services essential to the wellbeing of persons with mental illness.

In order to accomplish the integration of mental health programs within the health care system, several specific problems must be addressed. Mental health services are a specialized set of health services, but they have become organizationally established in isolation from other health programs. Familiarization of clinical staff in both health and mental health with the other discipline approach needs to be accomplished in order for mental health services to become more well integrated into mainstream health care. Through linkages established under this authority, it is anticipated that necessary procedures to achieve integration will be accomplished usually through the employment of an individual whose principal function is liaison, not clinical care.

The specific problem to be addressed through linkages include the needs of individuals using health services to mental health services; the needs of persons receiving mental health services for health care; continuing education of clinical providers to expand their orientation to include relationships between health and mental health or emotional problems and needs for community education about mental health services and the persons who use them.

Section 210(a) and (b) describes the content of the application for a contract under Title II of the Committee's bill.

Information to be submitted by an applicant includes: a discussion of objectives, services to be offered (or omitted if the need is already being met by another organization), plan for financing program, budget, schedule for fees and discounts, coordination of program with other mental health and support services, and provision of services in appropriate languages and cultural contexts where substantial portions of the population are bicultural or of limited English-speaking ability. The applicant must also assure that grant funds will be used to supplement, and to increase, where practicable, the level of non-Federal funding and not to supplant non-Federal Funds; that conditions of eligibility will be met; that there will be consultation with interested groups who are to be given an opportunity to comment on the application; that adequate records will be maintained; and that reports, statistics and other information will be furnished as requested by the Secretary.

Other information required will be detailed in "applicable regulations" prescribed by the Secretary. This latter provision will enable the NIMH to add other necessary items to the application such as the results or benefits expected, the estimated impact on the service area, priorities in time-frame established, etc.

Sections 211(a)(1) and (2) of the Committee's bill specify requirements for applicants whose primary purpose is to provide special mental health services or which seek to provide comprehensive mental health services funded under this Act. It reinforces the importance of responsiveness to community needs and to the potential or current consumers of these services by requiring governing or advisory boards for applicants seeking to provide services under this Act. Applicants which are not hospitals or public agencies must have governing boards with authority over budget, selection of the director, and overall policies of the program. Persons selected for these boards should be (if at all practicable) from the service area, and should represent the demographic, economic, and social groups of that area. At least half the board members should be persons who are not providers of health care. Hospitals and public agencies, in recognition of their inherent public accountability, are required to appoint advisory committees, similar in structure to governing boards, to advise on services to be provided by the applicant with funds under this Act. Entities which receive assistance to provide services under this Act but whose primary purpose is to perform other functions shall establish, at minimum, advisory committees for the services assisted under this Act.

Applicants which are recipients of support under certain sections of the Public Health Service Act (hospital-affiliated primary care centers, migrant health centers, community health centers) are subject only to the governance requirements of their respective legislative authorities.

The Committee intends that Sections 211(b)(1) and (2) provide the legislative framework to encourage and reinforce the efforts of communities to coordinate and integrate community mental health services in order to assure a flexible yet comprehensive service system. Therefore, this section emphasizes development of explicit written agreements among providers of mental health services in a community.

In communities where a community mental health center, which has been or currently is a recipient of funds under the Community Mental Health Centers Act (as amended), exists and another provider is seeking to enter a contract under this Act, the applicant is required to seek a formal agreement with the CMHC specifying the nature, procedures, and mutual responsibilities of the entities. It is not intended however, that the funding to the applicant would be denied if such an agreement could not be established. "Reasonable effort" is expected. Guidance indicating how reasonable efforts would be demonstrated should be developed by the Secretary.

In communities where the appplicant is a State agency, the legislation recognizes that formal agreements may not be consistent with State policy and therefore provides some latitude by requiring coordination or indication of efforts to secure such coordination with existing CMHCs. The Committee intends that such variations in State policy should not and must not prevent the development of coordinated service systems at the local level.

This section also requires similar negotiation and coordination between existing mental health service providers in regard to a CMHC applicant from the same area. If an applicant is applying for funding

to plan or implement a comprehensive mental health service program in the area, it must secure or attempt to secure explicit agreements with other mental health service providers in the area. The Committee does not intend that this requirement create a monopolistic control over services in the area by the CMHC, but rather this is intended to assure that there is continuity of services and that potential gaps in service or potential barriers to access which might result would be resolved in advance.

Again, the special problems of a State operated agency are recognized and coordination with local service providers is required on the part of the State-operated program.

Section 211(c) requires that all applications to enter contracts under this Act must contain assurances that each of these services intended to be provided through that contract are consistent with the State health plan that has been established. It is intended that the State Health and State Mental Health Authorities will coordinate their planning processes in regard to the development of services.

Section 212(a) requires State agencies which enter contracts to provide community services to include local public and community non-profit providers of services to the maximum extent possible. This section is not intended in any way to discourage any State from directly establishing and providing community mental health services itself through entities of the State. It also may not be appropriate to fully include those local providers who do not provide an adequate range of service; whose services are not readily accessible and available to all persons in the target recipient group; or whose services are not of sufficient quality or are not performed in an economical and efficient manner. In cases where the State finds the local providers to be deficient in any of these listed ways or in ways that are similarly significant, or in any other case where the state contends that it is appropriate to limit the involvement of existing local providers, the State will be required, through means elaborated by the Secretary, to justify such limitations or exclusions.

The Committee is concerned that actions taken to reduce unwarranted or inappropriate institutional care by placing persons in more appropriate community settings are sometimes not accompanied by adequate arrangements to protect the interests of affected employees who work in the large institutions which are de-emphasized. The Committee believes that States receiving Federal funds related to such actions should address this problem. Therefore, the bill directs the Secretary of Labor to establish regulations which require fair and equitable arrangements to protect the interests of these employees, and stipulates that a State Agency must be in compliance with such regulations to be eligible to enter into a contract under Title II of the bill. In order to help assure that as many relevant factors as possible are considered, the Secretary of Labor must provide an opportunity for consultation for the Secretary of Health and Human Services and for the Governor of any State prior to establishing regulations in this regard.

Section 212(b) requires that the Secretary of Labor—who operates an employee protection service within the Labor Management Services Administration and has had substantial experience under the Urban

Mass Transportation Act and the Rail Passenger Service Act—develop similar protective arrangements for employees adversely affected by reorganization of various delivery systems. The Committee recognizes that major dislocations of institutional personnel will take place as States continue to deinstitutionalize patients into the community and as more patients are treated in community-based settings rather than in institutions. The Congress has consistently provided for protections for employees, and in this legislation, the Committee intends that States and community mental health centers make maximum use of employees of State mental hospitals in the treatment of patients in community settings.

Consequently, an integral part of the performance contract arrangements under this Act must be protective arrangements devised as a result of detailed regulations by the Secretary of Labor. These will include such items as:

1. Negotiated arrangements between collective bargaining representatives and the States to protect employees (as has been the case under the Urban Mass Transportation Act), including such items as:

a. retraining, training, protection of pension, fringe benefits and other arrangements

b. protection of pay compensation, so that an employee at a particular pay scale is not required to take a job at a lower level of pay or responsibility

c. provisions for severance pay, comparable to that under the Urban Mass Transportation Act.

2. Provisions for protections of employee contracts such that when a State chooses to operate its own community mental health center it provides that the center is staffed by employees who may be under contract with the State for institutional services.

3. Similarly where community mental health centers provide services with out-stationed State hospital employees and directly hire former State hospital workers, that those employees receive full protections under the protective arrangements negotiated pursuant to regulations of the Secretary of Labor.

The Committee intends that these protective arrangements be adapted to the varying situations that can occur. Not all protective arrangements will be needed in all circumstances, but full and complete protections for each employee is absolutely essential to any States receiving funds under this Act.

The Committee believes that the Secretary of Labor should recognize and take into account the States financial circumstances and their legal requirements. The development and provision of services in community-based settings are of great importance to the Committee, and are strongly encouraged by this bill so that chronically mentally ill persons can be properly served in their home communities when such a setting is appropriate for the individual needing care. Community settings are appropriate only if adequate services and qualified personnel are available when needed. The costs of both funding these services and personnel and meeting employee protection requirements may be prohibitively expensive relative to a given state's financial cir-

cumstances. The Secretary of Labor should develop regulations that are sensitive to this potential problem; otherwise, such combined costs may be so burdensome that they could prevent a State from transferring inappropriately institutionalized persons to community settings as encouraged by this bill.

In dealing with State financial circumstances and State legal requirements, the Committee recognizes that some protective arrangements might prove more difficult to implement than others. It is the Committee's intention that the paramount concern of the Secretary of Labor be to work with States and employees to assure comprehensive protections for each affected employee similar to the Health Planning Amendments of 1979 and the Urban Mass Transportation Act. Between equally adequate protective arrangements that meet the requirements of the Health Planning Act and the Urban Mass Transportation Act, however, it is the Committee's intention that the Secretary of Labor may, if he chooses, consider State legal and financial restrictions as factors in approving one protective scheme over the other.

In dealing with the States legal requirements the Committee also recognizes that State law in some States may already address the question of and provide protection for employees affected by institutional closure and conversion somewhat differently than might general regulations issued by the Secretary of Labor. The Secretary of Labor should be sensitive to this possibility, and is therefore authorized to take such legal circumstances into account in developing and applying the regulations to be issued under the terms of this subsection.

The Secretary of Labor must promptly identify those States which are out of compliance, and the Secretary of Health and Human Services must take prompt action to require compliance with the protective arrangements by those States. Should there be any violation of these protective arrangements after a hearing and notice to the States, funding shall be terminated to that State.

The Committee encourages community mental health centers to take maximum advantage of State mental hospital workers who are affected by this legislation.

Section 213 establishes eligibility factors for States that wish to be exclusive contractors to perform the functions established in Section 216 if they also meet the requirements of Section 217. In order to qualify for such a contract, the State must meet a number of requirements showing satisfactory performance in meeting the needs of persons disabled by chronic mental illness. These requirements, if fully met, would constitute the basic elements of an effectively functioning Statewide community support system for this population.

Basically the State would be required to implement its mental health operations program and show "good faith" efforts towards meeting the needs of persons who are chronically mentally ill. The Committee believes that States which wish to be exclusive contractors must improve access to and coordination of services at all levels for persons who suffer the most severe disabilities from mental illness. In seeking more diverse roles in assisting the mental health needs of all citizens and their communities, States must assist and maintain quality leadership in improving the lives of the most seriously ill.

Thus, this legislation would require States seeking exclusive contractor status to:

Monitor community placements of chronically mentally ill persons, avoiding over concentration in certain areas; such monitoring should be accomplished with full respect for the privacy and other rights of former patients.

Provide support and placement services and standards for follow-up care including:

Discharge planning including notification of community service providers;

Prerelease consultation including medical, social, and economic status review;

Written treatment plan and case manager services

These plans should involve patients and their families in the planning; should include follow-up supportive work and potential living arrangements; should describe how and by whom services will be provided; and should include provision for regular reviews of the plan.

States seeking exclusive contractor status will also be required to:

Develop regulations and monitoring procedures for multi-occupant residences. This will include standards for both the facility and for needed linkages with services including case management; provision for access by families, friends and service providers; evaluation, inspection and monitoring procedures; remedies for non-compliance; and provisions for appropriate training of employees of multi-occupant residencies.

Develop public information and training programs to teach the community about the needs of chronically mentally ill persons.

Develop training and retraining programs for personnel in the mental health delivery system.

Do an annual progress review, report to the Secretary annually, and show the State's progress in diverting increasing funds to local non-institutional programs and services. This should include providing future projects for transferring budget funds from institutional activities to community based activities.

The Committee's concern about substandard conditions in unlicensed multi-occupant community residences is the basis for the regulation requirement established under Section 213(a)(3). The Committee hopes that this requirement will improve the group living arrangements of chronically mentally ill individuals and will build on and strengthen the commitment of States to implement and enforce the standard setting requirements of Section 1616(e) of the Social Security Act. The Committee does not intend that health care facilities, including hospitals, skilled nursing facilities and intermediate care facilities, which are already regulated by existing State or Federal law, be subject to the regulatory program required by this section.

Section 214 requires that no later than 330 days before the beginning of each fiscal year, the Secretary shall determine and announce which State agencies have met the requirements of Section 213. The committee intends that the Secretary will make available to States the technical assistance they may require in developing a program to meet the requirements of Section 213. Such assistance may be provided through direct staff or short-term consulting services by experts in such pro-

gram development. The Secretary shall designate appropriate staff to organize this program of technical assistance.

Section 215 creates an orderly process of planning and coordination of plans for the most effective use of Federal funds consistent with national goals and priorities. It establishes a process and timetable for application development and review at the local and State levels, and submission to the Federal level. It further affords a State the opportunity to exercise more leadership in State-local planning coordination and program development and maintenance, and to share with the Federal Government in administration of funds.

The Committee has stipulated that all applications by public and non-profit private entities to enter into contracts under this Title, except State agency applications, shall be submitted to the State agency no later than 270 days before the first day of the fiscal year for which funding is sought. Prior to submitting the applications to the state agency all public and non-profit entities must first submit them to a health systems agency. The health systems agencies may in turn offer its recommendation and comments to the State agency at any time prior to the transmission of such application's to the Secretary. While these comments do not have the nature of a formal review they represent the input of the local community as to the need and adequacy of the applications and should be taken into consideration by the State agency before sending the applications to the Secretary.

If a state agency applies for its own contract under this title it is required to submit such application to the affected health systems agencies at least 270 days prior to the first day of the fiscal year for which funding is sought under this Title. Health systems agencies may submit their comments and recommendations regarding these applications to the state agency at any time prior to the transmission of such applications to the Secretary. The Committee believes that through health system agency review and comments, the coordination between state and local needs can be maximized.

When State Agencies are the exclusive contractors for services, the Committee requires that 270 days prior to the first day of the fiscal year for which funding is sought, the State Agencies must submit the performance contracts to the Statewide Health Coordinating Council established under Title XV Public Health Service Act. The Statewide Health Coordinating Council may submit comments and recommendations to the state agency prior to submission of the contract to the Secretary.

It should be noted that the Statewide Health Coordinating Council may choose to comment informally with regard to the state contract. Notwithstanding its informal comment the SHCC has responsibility under section 1524(c) (6) to make an annual review and to recommend approval or disapproval of any state plan, any application, or any revision of a state plan or application submitted to the Secretary as a condition to the receipt of any funds under this Act. Therefore the state mental health contract must be considered by the SHCC as part of its statewide review of the proposed uses of federal funds under Title XV of the Public Health Service Act.

This section further provides for a process of appeal and renegotiation, in case of inability to achieve agreement between a local-level ap-

plicant and a State Agency, and in absence of resolution a direct appeal to the Secretary for resolution. It is the belief and intent of this Committee that negotiation between interested parties within the State, with the facilitation of the Department of Health and Human Services when appropriate, will be successful and that appeals requiring Secretarial decision should seldom be necessary.

Section 216 clarifies that it is the responsibility of the Secretary with respect to awarding of funds, to select only those applications consistent with the State health plan and with the provisions of this title, and those which, in the judgment of the Secretary are most likely to:

Provide priority population groups with the most effective and broadest services;

Provide the general population with the most effective and broadest services;

Lead to the provision of comprehensive mental health services for all persons in every mental health service area;

Provide for the maximum feasible utilization of private and public non-Federal resources, including private and public forms of health insurance; and

Provide staff that is bilingual and bicultural where substantial portions of the population to be served are of limited English-speaking ability, or bicultural, or both, provide services in appropriate languages and cultural contexts.

This section also requires that the Secretary make public the principles upon which judgements will be based, and for appropriate feedback to all applicants.

Section 217(a) specifies that a State Agency or a unit of local government, or a private nonprofit entity may, upon acceptance of an application to do so, enter into a "performance contract" with the Secretary to provide mental health services in a given area. In the instance where a State Agency is the recipient of a "performance contract" it is authorized to subcontract with other entities within the State to provide services. Sections 217(b) items (1) through (13) establish specific requirements to be included as part of the "performance contract."

Section 218 establishes the authority of the Secretary to enforce the requirements of the "performance contract." Based upon determination that the entity has not reasonably complied with the contract requirements, the Secretary may terminate funding, and refuse funding of further applications from the entity.

Section 219 expands the services funding capability of existing legislation and complements the services funding capability of this bill by allowing the Secretary to accept applications and enter into contracts under this section for the provision of services related to mental health, including rights protection and advocacy services, that he determines to be innovative in that they propose new approaches that improve on traditional methods of increasing the quality of services or modify current practices to better meet the needs of high risk population, and are of national significance and consistent with Department priorities. By including for-profit organizations among the eligible recipients in this Section, the Committee intends not to foreclose any proposal to provide better care for patients.

Section 220 provides that each contract under this Title shall be for a period of up to one year, as the Secretary may determine.

Section 221 stipulates that any service supported under this Title may be provided directly by the contracting entity, or by arrangement with other entities or health professionals. Such arrangements should be described in written agreements and in a form enabling the contracting entity to fulfill its responsibilities under the requirements of the award.

Section 222 enables the reduction of payments for the current fiscal year by the amount of excess, unobligated Federal funds from prior years, to the extent that previous such adjustments have not been made, and to the extent that such funds have not been allowed as awardee reserve funds. This Section also authorizes the awardee to retain a portion of such excess funds, amounting to up to 5 per centum of costs of operation of the recipient's program, for deposit in a reserve fund maintained for purposes approved by the Secretary.

Section 223 establishes particular support duration and level limits, designed to implement the goals and priorities of this legislation.

No more than eight fiscal years of support shall be available for provision of the same mental health service in the same mental health service area, except as noted below with respect to support for non-revenue producing services pursuant to Section 208.

Previous years of staffing grant and/or operations grant support shall be included in determining duration of support under this Section. Such support may not exceed 90 per centum of the cost of services for the first two years of funding, with the maximum declining gradually to no more than 30 per centum for the eighth year of funding.

An entity no longer eligible to receive support because of already receiving the above eight years, is eligible to apply for and receive support under Section 208, non-revenue producing services, not to exceed $1.50 per capita of the population of the affected area, for such periods and amounts as determined by the Secretary. The Committee intends that such support will be of limited duration and that each entity applying for such support will plan to reduce and terminate dependence upon this Federal support as rapidly as possible.

The Committee intends that any entity that has received support under Section 202, 203, 204, 205, 206, 207, or 209 of this Title, for eight years, or has terminated such Federal support as no longer needed, and which thereafter continues to provide substantially the same level of and type of services for the same population for which it received funding under such Section, may receive funding to provide different services in the same mental health service area or areas under any other such section. This provision is not intended to provide support for services for which support has already been received.

This section also requires that a minimum per centum of all Federal funding under this Title within each State, from no less than 5 per centum of fiscal year 1982 funds to no less than 20 per centum of fiscal year 1985 funds, be awarded for outpatient treatment and care and related support services for chronically mentally ill individuals, as defined by the Secretary. In order to implement this provision the Secretary may reduce any awards or not make awards with respect

to any State in such manner and in such amounts as he determines best.

This section further establishes minimum and maximum per centums of all available funding under this Title, which the Secretary shall obligate for mental health services to chronically mentally ill individuals under Section 202, ranging from no less than 10 per centum and no more than 20 per centum of fiscal year 1982 funds to no less than 20 per centum and no more than 30 per centum in fiscal year 1985.

Moreover, in recognition of the responsibility of CMHCs to provide mental health services to chronically mentally ill individuals, no less than 20 per centum of federal funds allocated under section 207 for CMHCs shall be used for this priority population group. Each CMHC receiving funding under section 207 shall account for its direct use of resources toward the treatment and care of the chronically mentally ill individuals. The Committee expects that the plight of the chronically mentally ill will be significantly improved as the provisions of this section are implemented, and directs the Secretary to submit an annual report of the extent to which the specific funding provisions for the chronically mentally ill have been used.

The Secretary may not award more than 5 per centum of funds under Section 207 to entities which do not meet the governing board requirements of Section 211(a)(1)(A), under the provisions of Section 211(a)(1)(B). It is the Committee's intent that exercise of this provision, insofar as Federal support is concerned, be limited. In order to implement this Section the Secretary shall, if necessary, make awards in accord with such priorities as he determines most appropriate in accord with the intent of this Act.

Finally, at least 90 per centum of the Federal funds for each award under this Title, shall be used to provide services at the local level.

Section 224 provides that the Secretary (1) may approve the use by an entity of a portion of the Federal funds provided to it to evaluate its mental health service activities, (2) shall set aside a portion of the appropriation to evaluate and monitor the use of Federal funds by entities receiving them to assure compliance with requirements and achievement of the purpose for which the funds are provided, and (3) shall use up to 2 percent of the annual appropriation for this Title to provide technical assistance and training to staffs of States and entities receiving Federal funds to assist them in improving their management and administration of their mental health service programs.

The Committee received testimony concerning the inadequacy and general lack of evaluation programs in the centers. To date, HEW has not encouraged adequate on-going evaluation of CMHC programs by the centers themselves. Thus, the Committee's bill requires the Secretary to use such funds it receives for an evaluation of its programs. Such evaluations should be at the Federal, State, and local level.

Section 225 contains Conforming Amendments which amend five areas of Federal Acts other than the Mental Health Systems Act so as to make them mutually compatible. The most critical of these conforming amendment adds to the requirements applicable to community mental health centers under the Community Mental Health

Centers Act relating to provision of followup care for residents of its catchment area (the "mental health services area" in the Mental Health Systems Act). The amendment, which affects section 201(b)(1)(A)(iii) of the Community Mental Health Centers Act, directs: that followup care must include designation of a case manager responsible for the coordination of services for each resident discharged from a public inpatient psychiatric facility and for the development of an individual treatment and services plan for each such individual; that such individual shall receive pre-release consultation from staff of the community mental health center or others with whom the center has made appropriate arrangements; and that each community mental health center must prepare, annually, a report to the State Agency describing the manner in which the needs of chronically mentally ill individuals in the catchment area are being met. This amendment conforms to many provisions of the Mental Health Systems Act and insures that its terms and those of the Community Mental Health Centers Act function synchronously toward common goals.

Section 226 is intended to enable entities serving American Indians and Alaska Natives to participate as fully as other entities eligible for the funding programs authorized by this Act. Mental health problems among American Indians, caused by such factors as cultural disorientation and poor living conditions, are extremely severe, as manifested in the high suicide and alcoholism rates found among American Indians. Indian tribes and urban Indian health centers, along with the Indian Health Service, have expanded their capacity to deliver a range of health programs to Indian people. However, restrictions in the original Community Mental Health Centers Act prevented tribes and urban Indian health programs from using that legislation to increase and improve the level of mental health services provided to Indian people. To correct that problem, other provisions of this Act include reservation and urban Indians within the definition of priority populations. In addition, the Act makes Indian tribes and urban Indian health programs eligible to apply for and receive funding under the programs authorized in sections 102 through 109 of Title I of this Act.

Section 226 assures that the funding provided pursuant to sections 202 through 209 will be available through funding routes that are compatible with the special legal position of Indian tribes and with the working relationship that exists between Indian Health Service, Indian tribes and urban Indian health programs.

Section 226(a)(1) makes this Act compatible with the National Health Planning and Resource Development Act, as amended, by recognizing tribal self-determination, the special sovereign status of Indian tribes and their direct relationship with the federal government. It gives tribes the option of submitting proposals directly to the Secretary, without having to go through the process of State approval and consolidation of proposals that is set forth in section 101 and other sections of the Act. The tribal government or an intertribal organization are the only entities under this section that may submit proposals directly to the Secretary. It is the intent of the Congress that a tribe or intertribal organization may submit proposals for as many different programs, under as many sections of the Act, as it chooses. But all components of the proposal must be consolidated into a single applica-

tion to be submitted by the tribal government or intertribal organization and there shall be only the one consolidated application per year from a tribe or intertribal organization. If a tribe or intertribal organization chooses to submit an application directly to the Secretary, no entity proposing to provide services that will specifically and primarily serve Indians located on that reservation or reservations may submit a proposal to the State agency or the Secretary pursuant to the provisions of section 101 of this Act. This will promote coordinated planning and delivery through a single entity—either the tribal government or the intertribal organization, which are the appropriate entities under the federal government's self-determination policy.

The Section also recognizes that in some areas of the country, particularly in California, tribal governments have designated intertribal organizations as the entities to deliver health care to their members. Under this section, such intertribal organizations are also authorized to submit proposals directly to the Secretary pursuant to this section, so long as the proposal is accompanied by authorizing resolutions, comparable to those required by the Indian Self-Determination Act, from each affected tribe. Any tribe participating in such an intertribal proposal may not submit a separate proposal on its own, since one of the purposes of this section is to provide a single point of responsibility for the delivery of mental health services to covered Indians.

Section 226 (a)(2) provides that for proposals submitted and approved pursuant to the provisions of subsection (a)(1), the Secretary shall enter into a single performance contract with the tribal government or intertribal organization (except for funding provided pursuant to subsection (b) where the Secretary shall develop an interagency agreement involving the Indian Health Service, which shall have the same effect as an annual performance contract). The tribal government or intertribal organization may, in turn, subcontract with other entities to deliver some or all of the services for which funding is provided. However, the tribal government or intertribal organization has final responsibility for such programs and shall be provided with indirect cost dollars sufficient to permit it to meet this responsibility.

Urban Indians are one of the priority populations under this Act, and urban Indian health centers are one of the entities eligible to submit proposals under this Act. Since urban Indian health programs do not have the same sovereign legal status as do federally-recognized Indian tribes, proposals submitted by urban Indian health programs must follow the processes set out in section 101 of this Act. However, when considering proposals submitted by urban Indian health programs, local and State agencies shall be responsive to the fact that urban Indian health programs have been specifically recognized by the Congress (in Public Law 94–437) as playing an important role in providing accessible and culturally sensitive services to Indians living in urban areas.

While the funding and delivery routes permitted, but not mandated, by this section are somewhat different from those available to non-Indian entities, this Section does not create any special entitlement program for Indian tribes. The Congress expects the Secretary to fund tribal Indian programs under this Act at a level commensurate with their needs relative to the needs of all other populations eligible for funding and services under this Act and commensurate with the merit

of tribal Indian program proposals relative to other program proposals. To enable the Congress to periodically review the relative appropriateness of the level of funding channeled through this section and the appropriateness of the special mechanisms as well, the Committee requests that the Secretary collect relevant data on services applied for and provided under this Act by and to Indian tribes. The Committee also urges States and tribes to work cooperatively in the delivery of mental health services, and encourages (1) States to recognize the needs of American Indians and Alaskan Natives; and (2) Indian tribes or inter-tribal organizations to cooperate with the statewide mental health planning and funding system encouraged by this Act.

Subsection 226(b) permits a tribe, inter-tribal organization or urban Indian organization, when submitting a proposal to the Secretary, to request that if the proposal is funded, the funds go directly to the Indian Health Service. This is intended to serve two purposes. First, many tribes, inter-tribal organizations and urban Indian organizations do not have the technical capacity to establish a mental health program and would prefer to tap the expertise available in the IHS. Secondly, this will permit a tribe to have its mental health programs funded under this Act integrated with the other health services delivered to its members by IHS, thereby promoting comprehensive health care. The decision to use this subsection is solely that of the tribal government, inter-tribal organization or urban Indian program.

The Committee instructs the Secretary to direct the Indian Health Service to assume primary responsibility for assisting Indian and urban Indian entities funded under this Act to identify sources of replacement funding as funding provided under this Act decreases and ultimately terminates pursuant to the terms of section 111 of this Act. Where other sources of funds cannot be identified, the Committee expects the Indian Health Service to request funds for this purpose as part of its own appropriations request to the Congress. The Committee recognizes that many tribes, inter-tribal organizations and urban Indian programs lack the independent sources of funding necessary to assume full financial responsibility for programs such as the ones in this Act. It is also aware that for previous programs where the federal contribution decreased or terminated at a certain point, the Congress was faced with urgent, last minute requests from tribes or other Indian entities to help them keep important programs from ending because, due to inadequate planning, there was no available money to replace the decreasing federal amount. The Committee therefore expects to see careful long-range planning, pursuant to the instructions set out in this paragraph, to insure this kind of problem does not occur for programs funded under this Act.

Section 227 of the Committee's bill relates to mental health traineeships. For many year NIMH has provided support to students for training in the mental health disciplines, with no requirements placed on their subsequent activities. Because of the many needs which have been identified for trained personnel, it is the intent of this section to require a service payback from students in the four major professional disciplines to assure that they work in those areas of need. In the Committee's bill the payback provision is limited to these students for several reasons:

(1) These disciplines constitute the majority of professional mental health manpower pool, and the need for this type of personnel are more identifiable. They are geographically mobile, with many employment opportunities, both in areas of need and in other settings. Payback restrictions would thus be meaningful.

(2) A system can be set up to identify areas of need for these professions. It would be costly and inefficient (if not impossible) to attempt to do this for the very small numbers of students in other disciplines who may receive NIMH support. These programs have usually been experimental in nature.

(3) Support of paraprofessionals is usually given for a specific purpose and for work in a specific location. Other employment opportunities are limited and private practice is not an option.

(4) Limited support is given to undergraduate students (almost always from minority groups) and programs to prepare these students for graduate training. Payback would be inappropirate, as the purpose is to increase recruitment into graduate training, and there is no need for personnel trained at the undergraduate level.

(5) Occasionally support is given for continuing education or short-term training of a few days or weeks. It is not feasible to require payback from these students.

(6) Experimental training programs may receive short-term NIMH support in order to study the effectiveness of new types of training programs. These programs are of a variable nature, and each trains a different type of student. A payoff is a research investment for the government, not the trainee. Payback regulations are not feasible or necessary.

Payback should apply, therefore, to all students enrolled in graduate training programs in psychiatry (residency training) psychology, social work or psychiatric nursing who receive traineeship support of six months or greater duration through clinical training grants awarded under the authority of Section 303 of the Public Health Service Act, as amended. After enactment of this legislation ADAMHA shall inform applicants for clinical training grants that obligated service will in the future be required of trainees. The Secretary shall, based on a study of current supply of and need for these mental health professionals, develop regulations defining the conditions for payback. These regulations will be distributed to all applicants for and holders of ADAMHA grants for clinical training in the four major professions. In addition, the Committee expects that a form will be developed outlining the conditions of payback, and given to any student seeking a traineeship. Only when the student has agreed, in writing, to these conditions may the traineeship be awarded by the training program. ADAMHA is further expected to develop a mechanism for tracking the educational course of trainees and ascertaining that the payback conditions have been met. Such a mechanism is already in place for payback obligations under the National Research Services Training Act, and can serve as a model for the requirements under this act.

The payback obligation would apply to all students who accepted a traineeship for support of granduate education in one of the four major professional disciplines subsequent to the distribution of regulations. It is not considered reasonable to expect or require a student to agree to obligated service when he/she does not know the conditions

or provisions of the obligation. It is expected that the Secretary will develop regulations promptly.

The Committee believes that ADAMHA should no longer support the basic training of professional personnel, but instead should target its funds on those elements of training which are focused on identified national priorities. For NIMH this may mean preparation for services to an underserved population group, such as children, the elderly, minorities, or work in underserved geographic areas or public facilities. It is expected that, in development of regulations around payback, the Secretary will consider the special training these individuals have received and the unique needs and places for provision of service of the different population groups. For example, someone trained in geriatric mental health should be encouraged to do such work, as is most beneficial to the elderly. In addition, no individual should be required to take a position where the standard of pay and other benefits is not commensurate with that obtained by others of similar training and experience.

The Committee believes that in designating the length of service required, the Secretary should require a month-for-month payback obligation when this obligation is for a period greater than a year. For example, support for 3 academic years of 27 months should result in a payback of 27 months, not 3 years or 36 months. Payback should begin within one year of completion of training.

It is not the intention of this provision to set up an alternative National Health Service Corps, or to have the Secretary locate or develop actual jobs for trainees having a payback obligation or to provide salaries for these individuals. ADAMHA has neither the staff nor the funds for this type of program, and it would not be a cost-effective mechanism. Rather it is intended that the Secretary, after studying the supply and distribution of professional mental health personnel, the diverse locations in which they are employed, the staffing ratios of facilities and the perceived need for such personnel, develop a list of the types of facilities and geographic areas or activities which have a need for mental health personnel. Criteria should be devised in such a way that areas, facilities or locations in greatest need are separable from those where a lesser need exists. Special attention should be paid to the inclusion of facilities or entities serving special population groups (children, the elderly, minorities, the chronically mentally ill, criminals and delinquents, etc.) and those in which mental health services may be performed, even though they are not part of the mental health system (schools, nursing homes, HMOs, hospitals, prisons, etc.). Individuals finding a job which they think meets these criteria should be required to obtain confirmation from ADAMHA. The Committee also intends that this program be fully coordinated with the National Health Service Corps.

The Committee also believes that there are some cases in which there is such a profound shortage that there is an urgent need for skilled mental health professionals for education and training, in order to extend their skills and knowledge. Examples include geriatric mental health, where many more training programs must be set up to improve the content of mental health training for general nurses. Where such a need exists, teaching in a particular content area could be approved as meeting the payback obligation. The Secretary shall also develop

a mechanism for approving deferral or other service in the case of hardship resulting from health or family problems.

Where an individual has a payback obligation under both this and another section of the PHS Act, it is the intent that, whenever possible, the same location may be approved to satisfy both requirements. In this way the individual will not be forced to change jobs and career activities unnecessarily, when both are considered to be in the national interest.

While developing this legislation, many members of the Committee were impressed by presentations outlining the role of the various creative arts therapies—art therapy, dance therapy, music therapy and psychodrama—in serving priority population groups, such as the chronically mentally ill, children and youth, the aged and racial and ethnic minorities. Using both verbal and non-verbal communication, the creative arts therapies reach mentally ill and emotionally disturbed persons who do not respond to traditional verbal therapy and are often unserved or underserved. The Committee understands that the creative arts therapies are among those services described in Section 201 (b) of the Community Mental Health Centers Act. It is also the intent of the Committee that creative arts therapies be included within the definition of mental health services under this Act. Many persons who could benefit from the creative arts therapies do not have access to them. It is hoped that greater use of the creative arts therapies will be facilitated through this legislation, especially through the provisions of services for the chronically mentally ill and severely disturbed children and adolescents, funding for innovative projects, meeting mental health service needs and development of bicultural programs. Furthermore, the Committee expects the Secretary to examine the barriers to the provision of the creative arts therapies to priority population groups and to recommend steps to alleviate or remove such barriers.

The Committee was also impressed with studies about the effectiveness of mental health paraprofessionals—workers with less than a baccalaureate degree. The willingness of paraprofessionals to perform outreach services, operate emergency or crisis line services, and locate in rural or other under- or unserved areas cannot be underestimated. Currently, over 4,000 graduates are being produced annually by approximately 170 paraprofessional college-level training programs. The Committee believes that the potential contributions that paraprofessionals can make as helping agents in the delivery of mental health services cannot be overlooked. The Committee therefore expects the Secretary to examine the breadth of paraprofessional clinical competence—their skills, deficiencies, and limitations—and to determine what are the most effective means of selecting, training, and supervising paraprofessionals.

TITLE III. RIGHTS AND ADVOCACY

The Committee's bill includes a Bill of Rights and an Advocacy program for the mentally disabled because it strongly believes that the Federal government has a clear and unequivocal responsibility to assure that mental health services are delivered with careful regard for the rights of those receiving them. In 1975 the Congress enacted a Bill

of Rights and an Advocacy System for the developmentally disabled The conference report accompanying that legislation stated:

> These rights are generally included . . . in recognition . . . that the developmentally disabled, particularly those who have the misfortune to require institutionalization, have a right to receive appropriate treatment for the conditions for which they are institutionalized, and that this right should be protected and assured by the Congress and the Courts.

The Committee in its deliberations found this statement persuasive and wished to extend similar rights to the mentally disabled.

The Committee's bill establishes a partnership among those responsible for funding or providing mental health services in order to make the mental health system more responsive to the needs of patients with emotional problems. The provisions of this Title are necessary to assure that patients are full members of that partnership.

There is broad-based agreement within the mental health field that the rights and advocacy program contained in this Title are necessary. Major mental health organizations including the National Mental Health Association, National Association of State Mental Health Program Directors, National Council of Community Mental Health Centers, National Association of Social Workers, American Psychological Association, Association for the Advancement of Psychology, as well as the Mental Health Law Project, American Bar Association, and American Civil Liberties Union have played a major and supportive role in developing this legislation.

The support of major mental health provider organizations is the clearest evidence, in the Committee's view, of their sincere desire to improve their programs and to better serve patients. This bill will inevitably create demands on providers. Yet in a letter on April 22, 1980 to the Committee Chairman, representatives of three of the most important national mental health organizations (the Mental Health Association, the National Association of State Mental Health Program Directors and the National Council of Community Mental Health Centers) strongly supported S. 1177 and its rights and advocacy provisions stating:

> This bill will bring needed reform to our mental health system, assure greater access to mental health care, and establish a set of legal rights and remedies for mentally ill patients. . . . By establishing a bill of rights and an advocacy program for mentally ill individuals, S. 1177 takes a *giant step* (emphasis added) in assuring that basic rights and liberties of individuals being treated for mental illness will be protected. The Mental Health Systems Act creates a balanced system of internal and external advocacy which will guard against unnecessary litigation.

The rights defined in the Committee's Bill apply to all persons who are admitted to programs or facilities for the purposes of receiving mental health services. The provisions in this Title do not apply to the offices of a private practitioner unless there is a formal written contractual relationship (other than or in addition to admitting privileges) with an inpatient facility for purposes of admission.

The Committee believes that the breadth of application of the Bill of Rights is necessary to assure minimal protections to persons receiving mental health services. There is clear Congressional authority to impose these requirements which can be found in the spending power clause of the Constitution as provided under Article 1, Section 8, Clause 1; (See, e.g., *Massachusetts* v. *United States*, 435 U.S. 444, 461 (1978); the due process clause of the 14th Amendment to the Constitution; (See, e.g., *Katzenbach* v. *Morgan*, 384 U.S. 641 (1966); and the commerce clause as provided under Article 1, Section 8, Clause 3 of the Constitution; (See, e.g., *Heart of Atlanta Motel, Inc.* v. *United States*, 379 U.S. 241 (1964), and "Constitutional Bases for Draft Mental Health Bill of Rights," Congressional Research Service memo to Senate Labor and Human Resources Committee, Mar. 28, 1980, and K. Wing and A. Silton, "Constitutional Authority for Extending Federal Control Over the Delivery of Health Care," 57 N.C. L. Rev. 1423 (1979).

The rights of individuals with special needs have been recognized in other federal legislation. The Committee does not intend the rights enumerated in this Title to replace those protections where both might apply. The rights established in this Title are intended specifically for the mentally ill. As such, the Committee intends these rights to apply to individuals whose presence in a program or facility is for the primary purpose of receiving mental health services without regard to the specific diagnosis. There are also many cases where a patient is admitted to a program or facility for other than mental health services but who subsequently need mental health services. When the primary purpose of that patient's presence in that program or facility becomes for the purpose of receiving mental health services, the Committee intends the rights under this Title to also apply. If only incidental mental health services are provided, the provisions in this Title do not apply. Thus participation in incidental programs such as reality orientation or occasional consultation about mental health services does not alone mean that a patient is entitled to the protections specifically set forth in this Title. Similarly, a resident of one facility who is receiving mental health services from a separate unrelated program or facility could not apply the rights of this Title to the residential facility.

The Committee's intent was to narrowly frame the rights in its Bill to apply to persons whose presence in a program or facility is for the primary purpose of receiving mental health services. They do not apply to other persons, programs, or services that may interact with the person in some way not connected with the program or facility to which he or she is admitted. Nor are these rights generally applicable to third party payors with respect to reimbursement for the services provided. The Committee does not intend that established procedures under the Social Security Act be affected in any way insofar as disputes regarding payment for mental health services may be concerned.

The Committee intends that remedies be available for rights violations which occur while a person is currently receiving mental health services. However exceptions are provided to assure that the individual's rights of confidentiality and access to records (rights 8 and 9) apply after discharge. "Mental health services" is intended by the Committee to include those support services, in addition to diagnosis and treatment for a mental disorder, that the *needed* in connection

with such treatment. For persons admitted on an inpatient basis, the range of these services will be much greater than for persons admitted on an outpatient basis, as they would include services connected with caring for the person on a 24-hour basis.

In considering this Title, the Committee carefully reviewed a survey of State statutes conducted by the Congressional Research Service which found that many jurisdictions provided for some rights for persons receiving mental health care; however, these were highly inconsistent and often ambiguous. Similarly, the Committee's review of judicial rulings found that these rulings have established many rights, but in varying terminology and applicable to individual jurisdictions. The Committee was careful to ensure that the provisions incorporated in this Title reflect those laws and court decisions and the extensive experience in interpreting them. Because of this disparity as to what rights apply in given situations, the Committee intends this section to establish a basic, though not comprehensive, set of rights for the purpose of assuring a greater measure of uniformity in their interpretation and implementation. The specificity of each provision is intended to provide guidance to both patients and providers concerning their rights and obligations.

In the Committee's view, the Bill of Rights, together with independent advocacy programs and internal rights protection programs, form a balanced system to protect the rights of persons receiving and providing mental health services. This Bill is not a comprehensive statement of all rights of (mentally handicapped) persons.[1] As the non-derogation clause (§ 301(b)(1)) makes clear, persons receiving mental health care already possess many rights as American citizens as well as other rights conferred on particular groups of citizens to which they also belong.

A. MENTAL HEALTH RIGHTS

1. The Committee believes one of the most important rights of persons admitted to a facility or program for the purpose of receiving mental health services is the right to receive appropriate treatment in the least restrictive manner. The right to appropriate treatment includes the right to receive such treatment in a manner or setting supportive of each person's personal liberties. By using the additional term "most supportive" of personal liberty, the Committee intends to emphasize the positive goal of the least restrictive alternative to enhance liberty, as clearly stated in the Report of the President's Commission on Mental Health:

> The right to treatment in the least restrictive setting is inextricably tied to the adequacy of treatment and the specific needs of each individual. The criterion "least restrictive setting" refers to the objective of maintaining the greatest degrees of freedom, self-determination, autonomy, dignity, and integrity of body, mind, and spirit for the individual while he or she participates in treatment or receives services. "Least restrictive setting" applies to both community and non-community-based programs.

[1] See generally, P. Friedman (ed.) *Legal Rights of Mentally Disabled Persons* (P.L.I., 1979) (3 vols.); B. Ennis and R. Emery, *The Rights of Mental Patients* (Avon, 1978).

The right to the least restrictive mode of treatment has been repeatedly recognized by federal courts as part of the rights of institutionalized mentally ill people (*Wyatt* v. *Stickney*, 325 F. Supp. 781, *enforced*, 334 F. Supp. 1341 (M.D. Ala. 1971), *aff'd sub nom. Wyatt* v. *Aderholt*, 503 F. 2d 1305 (5th Cir. 1974); *Covington* v. *Harris* 419 F. 2d 617 (D.C. Cir. 1969); *Dixon* v. *Weinberger*, 405 F. Supp. 974 (D.D.C. 1975).) It is rooted in the Constitution's protection of individual liberty against intrusions not necessary to the accomplishment of a valid legislative purpose; (*Donaldson* v. *O'Connor*, 422 U.S. 563 (1975), *citing Shelton* v. *Tucker*, 364 U.S. 479 (1960).

The Committee intends that no program or facility providing mental health services shall restrict the liberty of patients except as necessary for the provision of appropriate treatment or compliance with legal requirements or judicial orders, such as those pertaining to criminal offenders. The Committee intends that the exception for "other applicable requirements of law" and "applicable judicial orders" should be interpreted narrowly to refer to situations where a facility is required by law or court order to hold an individual in a more restrictive setting than his treatment requires. The Committee agrees with the approach taken in *Lessard* v. *Schmidt*:

> Perhaps the most basic and fundamental right is the right to be free from unwanted restraint. It seems clear, then, that persons suffering from the condition of being mentally ill . . . cannot be totally deprived of their liberty if there are less drastic means for achieving the same goal 349 F. Supp. 1078 (E.D. Wis. 1972).

Other leading cases which support the right are *Dixon* v. *Weinberger*, 405 F. Supp. 974 (D.D.C. 1975), now *Dixon* v. *Harris*, Civil Action No. 74–285; *Wyatt* v. *Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971), 334 F. Supp. 1341 (M.D. Ala.), 344 F. Supp. 373 (M.D. Ala. 1972), *aff'd sub nom. Wyatt* v. *Aderholt*, 503 F. 2d 1305 (5th Cir. 1974).

2. Each patient of a mental health services facility is given a right to an individualized plan of treatment to meet his particular needs. Congress has adopted similar requirements in the Developmental Disabilities Assistance and Bill of Rights Act and the Education for All Handicapped Children Act. Individualized treatment plans have been recognized by the President's Commission on Mental Health, professional associations, legal scholars and courts as essential tools for assuring implementation of the right to treatment on a personal level. On the right of institutionalized mental patients to an individualized treatment plan including periodic review, see Joint Commission on the Accreditation of Hospitals, *Standards for Psychiatric Hospitals*, (1978) at 10.2.3; *Wyatt* v. *Stickney*, 325 F. Supp. 781, 784, enforced, 334 F. Supp. 1341, 1343–44 (M.C. Ala. 1971), *aff'd sub nom. Wyatt* v. *Aderholt*, 503 F. 2d 1305 (5th Cir. 1974).

Judge David L. Bazelon, formerly Chief Judge of the D.C. Circuit, stated in a widely-cited article: "The need for an individualized treatment plan cannot be overemphasized. Without such a plan, there can be no evidence that the hospital has singled out the patient for treatment as an individual with his own unique problems. And unless the plan is refined and improved on the basis of experience, there can be no guarantee that the promise of treatment has taken root in reality."

(Bazelon, "Implementing the Right to Treatment," 36 *U. Chicago L. Rev.* 742, 746 (1969)).

The Committee finds that without a plan evaluating the unique condition of each patient and prescribing appropriate care and treatment to improve it, there can be no assurance that the right to treatment is being respected.

Review and reassessment of the plan should occur at regular intervals to assure re-examination of each individual's situation. The intervals should be appropriate to the length of stay. The specific requirement that the individual treatment plan describe the mental health services which may be needed after discharge is designed to require an assessment of service needs at time of discharge. Combined with the requirement of right 15 requiring referral where appropriate upon discharge, this right is intended to guard against "dumping" of patients without adequate planning or services. The requirement that treatment be "based on" the plan means that treatment actually provided should generally conform to the plan.

3. The Committee believes that the right to participate in the planning of the services one will receive is important. For this participation to be meaningful, a person should be as fully informed as possible. The Joint Commission on the Accreditation of Hospitals (JCAH) Standards require and provide a model which the Committee believes is applicable:

> 10.4. Each patient over the age of 12 shall be fully informed about the following items:
>
> a. his or her rights;
>
> b. the clinical staff responsible for his of her care and those staff members' professional status and staff relationship;
>
> c. the nature of the care, procedures, and treatment which he or she will receive; . . .
>
> e. the risks, side effects, and the benefits of all medications and treatment procedures used, especially when medications and treatment procedures are unusual or experimental; . . .
>
> g. the alternative treatment procedures that are available; . . .
>
> p. the discharge plans; and
>
> q. the plans for meeting continuing mental and physical health requirements following discharge.

The Committee intends that the person's individual condition and capabilities must be considered, but always with the goal of maximizing participation. If the responsible treating professionals make a clinical judgment that detailed information about the patient's condition or recommended treatment would be injurious to the patient's health, the patient's direct participation may be limited, but only to the extent necessary to avoid such injury. The specific reasons for such judgment should be documented and every reasonable effort should be made to enable the patient to participate to the full extent of his or her capabilities. This is spelled out in the JCAH accreditation standard 10.2.3(d) which provide that:

> The patient has a right to individualized treatment, which shall include at least the following:

> d. active participation of the patient over 12 years of age and of the responsible parent, relative, or guardian in the planning for treatment. . . .

In recommending a course of treatment, the provider has a duty to explain alternatives which are offered by that program or facility and answer questions. The requirement that a person be informed concerning his or her physical condition is not intended to require a physical examination for each patient.

4. The Committee recognizes that persons receiving mental health care have the same right as other persons to give or withhold consent to their treatment. Paragraph (4) requires that, prior to the initiation of a mode or course of treatment, the individual's informed and voluntary consent be obtained in writing, unless one of two narrow exceptions justify treatment without such consent.

The Committee adopts the view that a competent individual's rights to privacy and bodily integrity prohibit forced medical treatment in ordinary circumstances. This position reflects a growing body of legal precedent, statutory enactments and scholarly commentary that recognizes this right in the cases of confined mental patients.[2]

The key element to this right to consent to treatment is the individual patient's "competence"—i.e., one's ability to render an informed decision. The Committee has considered various arguments that such a right is superfluous because hospitalized mental patients are, by the very fact of their illness and confinement, incapable of making informed decisions. However, a diagnosis of mental illness is *not* to be equated with one's inability to make such decisions. According to Robert Sadoff, M.D., an eminent forensic psychiatrist who surveyed the literature:

> Mental illness, no matter how severe, should not automatically be equated with incompetence. Many individuals who are severely mentally ill are legally competent to conduct various aspects of business and make decisions about their lives. . . .
>
> Many individuals who have been hospitalized and who are psychotic may be competent to make decisions about their own treatment; to the extent possible this should be allowed. . . . (Sadoff, "Basic Facts About Mental Illness," in *Legal Rights of Mentally Disabled Persons* 176 (Friedman, ed. 1979)).

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[2] *Okin* v. *Rogers*, No. 77–1201 (1st Cir., Dec. 8, 1977), *on remand sub nom. Rogers* v. *Okin*, 478 F. Supp. 1342 (D. Mass. 1979); *Rennie* v. *Klein*, 462 F. Supp. 1131 (D.N.J. 1978) and 476 F. Supp. 1294 (D.N.J. 1979); *In re K.K.B.*, 51 O.B.J. 108 (Okla. 1980), 4 *MDLR* 77; *Goedecke* v. *Colorado*, 603 P. 2d 123 (Colo. Sup. Ct. 1975). Plotkin, "Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment," 72 *Nw. U.L. Rev.* 461, 504–25 (1978); "Developments in the Law—Civil Commitment of the Mentally Ill.," 87 *Harv. L. Rev.* 1190, 1350 (1975) ("patients committed under most current standards should have the right to refuse treatment, even if no statute explicitly grants them that right"); Note, "Advances in Mental Health: A Case for the Right to Refuse Treatment." 48 *Temple L.Q.* 354 (1975); Note, "The Constitutional Right to Treatment for Involuntarily Committed Mental Patients—What Limitations," 14 *Washburn L.J.* 291, 305 (1975) ("The nondangerous psychiatric inmate who refuses treatment should not have treatment forced upon him"); Schwartz, "In the Name of Treatment: Autonomy, Civil Commitment and the Right to Refuse Treatment," 50 *Notre Dame Lawyer* 808 (1975); Ferleger, "Loosing the Chains: In-Hospital Civil Liberties of Mental Patients," 13 *Santa Clara Lawyer* 447 (1973); Shapiro, "Legislating the Control of Behavior Control: Autonomy and the Coercive Use of Organic Therapies," 47 *So. Cal. L. Rev.* 237, 321, 323 (1974) ("The view that this issue [coercive treatment] is the exclusive province of medicine is gravely mistaken. . . . Nothing less than judicial review of decisions to compel highly intrusive organic therapy can adequately air the values at stake in such compulsion").

It has also been argued that once a court decides to civilly commit an individual, the state may in all cases treat his or her mental illness even if the patient refuses to consent. The Committee, however, is unpersuaded by this argument. While a judicial commitment authorizes one's physical detention, it does not automatically follow that the state may force a competent individual to undergo any and all forms of treatment. A patient still retains separate rights to privacy. Significantly, under the commitment laws in most states the decision to involuntarily hospitalize has no direct effect on the individual's competency. Competency is rarely an issue in such proceedings, and many states specifically recognize that commitment and incompetence are two separate and distinct legal conclusions. (E.g., North Carolina, North Dakota, Ohio, Rhode Island. See 72 Nw. U.L. Rev. 461 at 504-24 for a chart comparing all state laws on this issue.)

Thus, the Committee's recognition of this distinction is consistent with the view prevailing in most jurisdictions.

In recent years, the issues of whether and under what circumstances a judicially committed patient may be forced to undergo treatment have received considerable attention, and judicial decisions interpreting the Constitution are beginning to provide some clarification. (see e.g. *Rennie* v. *Klein*, 462 F. Supp. 1131 (D.N.J. 1978) and 476 F. Supp. 1294 (D.N.J. 1979)) The Committee's intention in this regard is to provide a means to assure that, to the extent under applicable law and judicial rulings a judicially committed patient has the right to be free of involuntary treatment, that right is enforceable. It is not the Committee's intention to attempt to resolve the many complex issues as to whether, when, and what treatments may be provided involuntarily.

Generally, the Committee believes that adults are presumed competent to grant or withhold consent, and they may be treated without personal consent only in emergencies or, after their incompetence has been determined in a court hearing and a guardian has been appointed, with the consent of the guardian. Consistent with this approach, section (4)(A) permits treatment without consent in "emergency" situations. Although this standard does not permit treatment personnel to liberally resort to the "emergency" exception for their own convenience or protection, the Committee recognizes that qualified mental health professionals must be allowed some latitude to determine the existence of a true emergency situation.

By adopting the language "a mode or course of treatment" the Committee intends to require written patient consent only to the type, manner, and pattern of treatment. It is not intended that a separate, written consent form be required for each pill, shot or treatment administered pursuant to the agreed-upon plan. However, it is intended that when broad changes in the mode or course of treatment are contemplated, a new consent is necessary.

Finally, the Committee expressly rejects any notion that a patient consent requirement will undermine treatment relationships and cause unnecessary delays. An excellent professional study has demonstrated that, to the contrary, such requirements may enhance the therapeutic relationship and promote a more speedy recovery. (Applebaum and Gutheil, "Drug Refusal: A Study of Psychiatric Inpatients," American Journal of Psychiatry, vol. 137, no. 3 (March

1980) at 345). Moreover that same article points out that most patients do not refuse treatment and when they do refuse treatment it is usually only temporary.

5. The exploitation of mentally handicapped persons as human subjects of experimentation has left a sad history of abuse.[3]

The Committee approves the approach taken by the Department of HEW (now the Department of Health and Human Services) in proposed regulations based upon the recommendations of the National Commission on the Protection of Human Subjects on protection of institutionalized persons in research (45 Fed. Reg. 53950 (Nov. 17, 1978)).

6. Many of the worst abuses of patients involve indiscriminate use of physical or chemical restraints. Restraints and seclusion have too frequently been used for the convenience of staff or as punishment. *Knecht* v. *Gillman*, 488 F.2d 1136 (1973) ("The use of this unproven drug for this purpose [quieting of mental institution inmates]. . .is, in our opinion, cruel and unusual punishment prohibited by the eighth amendment."); *Nelson* v. *Heyne*, 355 F. Supp. 451, 455 (1972) ("This Court finds shocking to the conscience and violative of the plaintiff's rights the defendants' present policy with respect to tranquilizing drugs").

Paragraph (6) prohibits restraints (except in an emergency) unless such restraints have been adopted as part of the individual's treatment plan, subject as always to the participation and consent requirements.[4] Behavior modification techniques involving restraint or seclusion would similarly require consent. Restraint is intended to refer to individual restraint, rather than to security measures such as locked wards designed to protect patients and staff.

The requirement of a humane environment applies while the person is on the premises of a program or facility. It includes privacy in caring for personal needs and hygiene but does not necessarily require a private room. The Committee approves the approach adopted in the case of *Wyatt* v. *Stickney:* "patients have a right to privacy and dignity." 344 F. Supp. 373, 379 (M.D. Ala. 1972), *aff'd sub nom. Wyatt* v. *Aderholt*, 503 F. 2d 1305 (5th cir. 1974).

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[3] *See, e.g., Murphy* v. *deVito*, No. 79–CO–1320 (Ill. Cook Cty Cir. Ct., filed April 1979). The complaint alleges experiments throughout the 1950's, 1960's, 1970's "apparently conducted in conjunction with the Department of Psychiatry at the University of Chicago." The techniques tested included various types of surgery (including removal of adrenal glands and lobotomies), drugs (including LSD) and various means of inducing shock. (Case histories of particular individuals are included in the complaint to show the deleterious effect of the experiments. One individual's case record shows severe debilitation that on June 15, 1956, the entry on her record recommends that she be transferrd to a different ward because she was unsuitable for further research. 3 *MDLR* 243 (1979); *New York State Ass'n for Retarded Citizens* v. *Carey*, 393 F. Supp. 715 (E.D.N.Y. 1975); *Report and Recommendations; Research Involving Those Institutionalized as Mentally Infirm*, National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, February 8, 1978, 43 Fed. Reg. 11328 (Mar. 17, 1978); *PCMH*, vol. IV at 1437 ff. Mont. Rev. Codes Ann § 38–1321 (Supp. 1977); N.J. Stat. Ann (West Supp. 1978) § 30.4–24 2d(2); N.Y. Mental Hyg. Law § 33.03(b)4 (McKinney 1978).

[4] The right of institutionalized mental patients not to suffer arbitrary and unnecessary seclusion and restraint is thoughtfully discussed in Brakel, "Legal Problems of People in Mental and Penal Institutions: An Exploratory Study," *Am. B. Found. Res. J.* 565 (1978), and Ferleger, "Loosing the Chains: In-Hospital Civil Liberties of Mental Patients," 13 *anta Clara Lawyer* 447 (1973). See, eg., Alaska Stat. § 47.30.140 (1975); Ariz. Rev. St. Ann. § 36–513 (West Supp. 1979); Conn. Gen. Stat. § 17–2063 (1979); Ga. Code Ann. § 88–502.5(b) (1979).

Standards for intermediate care facilities ensure that a resident "is free from mental and physical abuse and from chemical and physical restraints except as follows: When authorized in writing by a physician for a specified period of time; when necessary in an emergency to protect the resident from injury to himself or to others, in which case restraints may be authorized by designated professional personnel who promptly report the action taken to the physician. . . ." 42 C.F.R. § 449.12(a)(1)(ii)(B)(7).

This same policy is embodied in standards for intermediate care facilities promulgated under the Social Security Act, 42 C.F.R. § 449.12(a)(1)(ii)(B)(10): "[The facility must assure that each resident:] (10) is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs. . . ."

8. The Task Panel on Legal and Ethical Issues of the President's Commission on Mental Health (volume IV, p. 1399) strongly recommended that "(e)xcept where otherwise required by law, confidentiality of mental health information must be strictly maintained."

The Task Panel's recommendation was in accord with the congressionally authorized Privacy Protection Study Commission, which noted that "the medical-care relationship in America today is becoming dangerously fragile as the basis for the expectation of confidentiality with respect to medical records generated in that relationship is undermined more and more. A legitimate, enforceable expectation of confidentiality that will hold up under the revolutionary changes now taking place in medical care and medical recordkeeping needs to be created." Privacy Protection Study Commission, *Personal Privacy in an Information Society*, 1977, p. 306.

The Committee as well as the Presidents Commission on Mental Health Task Panel members were alarmed by the widespread use of blanket consent-to-release forms which asked patients to sign away all rights to confidentiality.

The Committee believes that confidentiality of medical (including mental health) records is an important right which has been discussed in the legal and professional literature; (see Brooks, *Law, Psychiatry and the Mental Health System*, ch. 10 (1974), for a general survey of the recent literature).

The inclusion of this right in the bill of rights assures that persons receiving mental health services can effectively enforce the new confidentiality protections incorporated in section 515 of the Public Health Service Act.

9. In the Committee's view, an individual's right of access to his or her own treatment records is important. The Committee recognizes that there may be a need for a limited exception to his right when seeking certain information in the record would be detrimental to the person's health; the provisions in paragraph (9) (B) are thus designed to assure that access to a person's own record is limited only in appropriate cases and not arbitrarily or as a matter of routine. The exception is intended to apply only to specific, identifiable parts of the record. If a health professional responsible for a person's mental health care determines that access to any specific material in his or her record would be detrimental to such person's health, the health professional must document that determination and the reasons for it in writing. The patient is then entitled to select another health professional to review the material to which access is proposed to be denied. That health professional must hold a license similar to that of the health professional recommending denial, to assure that the original determination and its reasons are fully understood and receive full consideration. If the second health professional, exercising his or her professional judgment, determines that the patient should not be

denied access to any or all parts of the records, such health professional may authorize such access or arrange for the disclosure of the information to the patient.

10. The Committee intends to assure as much freedom as possible for patients to exercise their constitutional rights of association and expression. Restrictions on specific visitors are allowed only if essential for treatment, must be fully documented and must be part of the treatment plan.

11. No right can be effective unless a person knows and understands it. The Committee intends that information about these rights should be made available both orally and in writing in an understandable manner to all persons at the outset of treatment and periodically thereafter. The latter is important to assure that those persons whose condition may have affected their understanding of rights, or their ability to exercise them, have a realistic opportunity to do so as their condition improves and to assure that persons receiving services fully understand that they may ask questions or change their minds about those services. The Committee does not intend that the rights be simply enumerated but rather that providers take the explanation of these rights seriously. The Committee does not intend for the patient's rights to be explained each time he or she receives a dose of medication; however, whenever significant changes in treatment take place, patients must be reminded of their rights so that they are free to ask questions or object.

Section 301(c)(5) requires that a listing of rights meeting standards established in regulations will be posted at convenient, prominent locations and that the listing be in English and in any other language spoken by a significant number of patients. Solely posting rights is not intended to satisfy the requirement for periodic information in terms appropriate to an individual's changing condition and ability to understand.

12. The Committee agrees with the Task Panel on Legal and Ethical Issues of the President's Commission on Mental Health that any adequate bill of rights must include an efficient enforcement mechanism. The report of the Task Panel stated (p. 1467):

> Optimally, there should be a grievance mechanism comporting with procedural due process, appointment of counsel and an automatic hearing procedure established in the case of the denial of any of the rights enumerated in a draft bill.

The Committee believes that each patient has a right to assert grievances and anticipates that virtually all complaints under this section will be resolved either informally or through grievance procedures required by paragraph (12). In view of the variety of programs and facilities, no particular grievance mechanism is specified; however, the Committee intend that regulations promulgated under this act will provide more detailed guidance. In the Committee's view, in order to be "fair, timely and impartial," any grievance procedures must provide an opportunity for the patient (with assistance from an advocate) to present information to a disinterested decisionmaker. The decisionmaker, for example, should not be a member of the patient's treatment team or responsible to those who have responsibility for that patient's treatment. The procedure and remedies should be responsive to situa-

tions requiring immediate action, such as allegations of physical abuse, and should provide protection against retaliation. Many facilities already have or will establish their own grievance procedures. The Committee intends the term "for or by" to permit, as an alternative, states, counties, cities, or impartial third parties, such as citizen organizations to establish grievance procedures under a contractual agreement for the use of patients of one or more facilities.

13. The Committee intends that every patient have the freedom to obtain advocacy assistance. In the Committee's view, such assistance is crucial if patients are to understand and meaningfully exercise all other rights. The Committee recognizes that advocates are not presently available for many patients of mental health services. Therefore this bill also includes provisions to promote availability of such advocates (Sections 303 and 306). The definition of "qualified advocate" in Section 306(b) assures that the right of persons receiving mental health care to access to advocacy assistance provides responsible advocates. Organization which wish to provide advocacy services though persons who are not licensed attorneys or employees of established legal services or advocacy agencies can be "qualified" by registering with the Governor. The administrative procedure for such registration, as provided in Section 307, is designed to assure that the Governor's determination that any such person cannot be registered is based upon objective criteria.

14. Patients are entitled to criticize or complain about conditions or services without fear of retaliatory punishment or other reprisals. Yet, mental patients have suffered reprisals for complaining about the conditions of their confinement, the course of their treatment or violations of their rights. See, e.g., *Brown* v. *Schubert*, 347 F. Supp. 1232, 1233 (E.D. Wis. 1972) (patients transferred from minimum to maximum security facilities "to punish [them] for writing [critical] letters"); *Rennie* v. *Klein*, 476 F. Supp. 1294, 1298–1303 (D.N.J. 1979), *supplementing* 462 F. Supp. 1131 (D.N.J. 1978) (excessive doses of forced medication as reprisal for complaining about drug side-effects or for contacting counsel).

Therefore such reprisals are specifically prohibited. But the Committee does not intend to limit the program or facility's right to discharge a patient, except where such discharge is in reprisal for the patient's exercise of or refusal to waive his or her rights, as provided in Section 301(c)(2). The test of whether a discharge is prohibited under this section is primarily a question of motive. If reprisal against the person admitted was a substantial element of the actual reason for that person's discharge, then the discharge is a violation of that person's right. The reprisal, to be prohibited, must be in response to the assertion of legitimate rights by or on behalf of that person. This section would not, in the Committee's view, permit a highly disruptive patient to use the assertion of clearly unwarranted complaints based on these rights to remain immune from discharge.

15. The Committee intends the right to referral to complement the discharge plan required in paragraph (2) to prevent "dumping" of patients without referral in those cases in which other services are advisable. The program or facility must make a reasonable effort to refer patients to suitable services, but does not thereby accept responsibility for providing such services.

Section 301(b)(1) of the Committee's bill makes clear that the rights provided in Section 301 are in addition to and not in derogation of any other statutory or constitutional rights. In the event that state law, constitutional law or other federal law provides broader protection in any given situation, that protection should govern. The Committee has incorporated various clarifications with respect to the bill of rights in paragraph 301(c). The prohibitions against either discharge or denial of admission as a reprisal for the exercise of the rights provided are intended to apply equally to situations in which a person refuses to waive such rights as a condition of further treatment or of admission. A narrow exception to this principle is recognized in section 301(c)(2)(C).

The Committee strongly defends the duty of mental health professionals to administer treatment according to their clinical judgment of what constitutes appropriate treatment for a person. The Committee does not intend that the observance of the rights established in part A require a mental health profesional to administer treatment contrary to that judgment. The Committee recognizes that the obligation to treat a person cannot continue if appropriate treatment has become impossible in the face of the person's refusal to consent to treatment or to restrictions necessary to support effective treatment, such as the restriction of access to certain visitors permitted under paragraph 10. Furthermore, the Committee does not intend for this part to require the admission of a person whose past refusals to consent to treatment while admitted to that program or facility supports the judgment that yet another admission would be futile.

Finally, the Committee does not understand this part to apply to persons admitted solely for diagnosis or evaluation. However, the Committee intends this provision to be interpreted realistically, so that the labeling of services as diagnostic or evaluative does not permit providers to avoid responsibilities under this part. In the Committee's judgment, the time-limited nature of diagnostic or evaluative admissions is a relevant interpretive factor.

The Committee believes that each right recognized in this part belongs to the person receiving mental health care. Subsection 302(d) is designed to cover those situations in which another individual may nonetheless act on behalf of the patient with regard to certain decisional rights when the patient is not able to make decisions for himself or herself. The Committee has provided for two such situations. Paragraph (1) referes to the adult who may be incompetent to make these decisions. It permits decisions to be made instead by a court-appointed guardian or representative, where the appointment is for the specific purpose of making such decisions. This procedure is appropriate, in the Committee's view, because it ensures that the determination of the patient's incompetency is made with adequate procedural protection for the patient. The Committee approves the trend among the states toward "limited" guardianships, which imposes time-limited restrictions on a person's autonomy only with regard to those matters specifically found to be necessary.[5]

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[5] See, e.g., ABA Commission on the Mentally Disabled, Exercising Judgment for the Disabled, 4 MDLR 47 (1980); Limited Guardianship Act, Tex. Prob. Code Ann. §§ 130A–D (Vernon Supp. 1978–79).

Paragraph (2) refers to the standing of minors under this Title. The Committee judged it appropriate to refer to existing state law on the question of when individuals are old enough to make such decisions for themselves. The Committee saw no need for the requirement of a hearing or court proceeding in the typical situation involving a minor.

The prohibition of conflict of interest in guardianship regarding treatment decisions incorporated in paragraph (3) is not intended to bar such persons from acting as guardians in matters which do not present such potential conflicts of interest.

Section 303 of the Committee's bill confers a civil action for relief from violations of Section 301 of the act upon any person who is or has been aggrieved by the alleged violation. Such person must demonstrate to the court that he or she has already asserted his or her claim through grievance procedures conforming to the requirements of § 301(a)(12), that such procedures have not been established and/or are not available, or that such procedures cannot afford timely relief.

The right of action under this section belong only to recipients of mental health services. The Committee does not intend that advocates should be able to bring such actions in the absence of an aggrieved patient, although safeguards for the patient's identity may be necessary to protect privacy interests.

The Committee anticipates that virtually all complaints under this part can be resolved through the grievance procedures required in Section 301(a)(12). However, it is recognized that some disputes will not be so resolved and that an independent private cause of action on behalf of persons aggrieved by alleged violations of the bill of rights is necessary for effective enforcement. Without the power to go to court, the person receiving services remains ultimately dependent on the system to police itself. Both the grievance procedure and the power to go to court will enable individuals to enforce their own rights and not rely on the Federal Government.

Section 303(c) of the Committee's bill provides for attorneys fees in limited circumstances. The language and approach of this provision is identical to that already in Federal law (42 U.S.C. Section 1988), which gives courts discretion to award reasonable attorneys' fees to successful litigants in cases brought under the Civil Rights statutes. The purpose and effect of this provision is simple—to allow the courts to provide the traditional remedy of reasonable counsel fee awards to private citizens who must go to court to vindicate their rights under this Act. In many cases that might arise under this Act, citizens whose rights have been violated may have little or no money with which to hire a lawyer and the limited attorney's fees will assist in the enforcement of important Federal rights.

Of course, since citizens would only recover fees under this bill if they were successful in their suits, this Act will do nothing to encourage frivolous or bad-faith litigation. In fact, by allowing assessment of fees against a "bad faith" plaintiff, it would have exactly the opposite effect. The Committee intends that in interpreting this provision, the standards for determining reasonable fees and the principles for applying the attorney fee provision will be the same as those set forth in the House and Senate reports accompanying the Civil

Rights Attorneys Fees Awards Act of 1976 (P.L. 94–559, 42 U.S.C. § 1988) and the cases cited with approval therein.

ADVOCACY

The Committee believes that mentally disabled persons often have special difficulties in protecting their own interests or enforcing their own rights. The Committee is carefully reviewing the need for a Mental Health Advocacy Program agreed with the conclusion of the President's Commission on Mental Health that "an effective mental health advocacy system must be created to protect the rights of all who receive services." (p. 42) Testimony at Subcommittee hearings on S. 1177 established that inadequate resources currently exist for this purpose. Other advocacy organizations such as the developmental disabilities protection and advocacy (P&A) system and the Legal Services Corporation do not fill the role.

The Committee found particularly compelling the testimony of Mr. Paul Friedman which said, in part:

> Mental health advocacy has now reached a crucial period in its short history. Just when programs have begun to gain real expertise and establish their credibility, most face the end of "seed" or other initial funding. The private foundations which have supported many projects in the formative stages now expect to "wean" them.

The Mental Health Advocacy Program provides support to begin development in States and local communities of specialized advocacy projects to help protect patients rights.

Many states already recognize their responsibility to help protect the rights of persons receiving mental health care, but funding for such programs have often yielded to other service priorities. Section 602 of this bill will provide a needed incentive for states to develop or expand rights protection programs within the mental health system. The Committee anticipates that internal rights protection programs will be able to resolve most problems informally or through administrative grievance procedures, thus minimizing the need for litigation.

Internal programs may include grievance procedures, ombudsmen and ombudswomen, staff training and other programs through which a state or a facility safeguards the rights of patients. Internal programs have been very helpful in such states as Wisconsin and Michigan. The Committee believes that such programs are an important part of a balanced system for protecting patients rights.

The Committee believes that internal programs are important but are not a substitute for independent advocacy. Advocates external to and independent from mental health service providers should be responsible and loyal only to the patient and their freedom to pursue remedies should not be compromised by fear of losing their jobs. If funding permits, such advocates should be able to also represent patients in the many areas outside the mental health system where the patient frequently faces discrimination or denial or rights, such as housing opportunities or receipt of Supplemental Security Income. In many such instances, the mental health provider cannot bring pres-

sure to bear on other agencies to assure the patient's access to needed services, without the help of an independent advocate. However, the primary focus of any advocacy program must be the enforcement and protection of the rights listed in Section 301(b). To assure independence from any conflict of interest, or appearance of conflict, the bill provides that the funding mechanism itself must be separate from any part of the Department of Health and Human Services which is identified with funding for mental health service providers. The Committee intends that the Legal Services Corporation should be involved in the MHAP in a planning and advisory capacity to the maximum extent possible to assure coordination and avoid duplication of effort.

The bill provides for funding of advocacy projects which meet certain eligibility criteria. The eligibility criteria and contemplated range of activities of MHAP projects reflect the successful experience of the protection and advocacy program (P&A) established in the Developmental Disabilities Assistance and Bill of Rights Act. A different grant mechanism was chosen to accommodate differences between federal funding of mental health and developmental disabilities services. The project grant mechanism reflects the pattern of federal funding of mental health services by individual project applications. The Subcommittee heard testimony that a variety of mental health advocacy models have been tried, including legal services and public defender projects, statewide advocacy offices, independent public interest projects and bar-affiliated projects. Many have been experimental programs, and despite notable successes, their ability to obtain funding has been severely limited. Some have been based at institutions, others in communities or at the state level. The Committee wishes to encourage the design of programs suited to the individual needs of the various states and communities and to avoid duplication of existing efforts. The MHAP gives broad leeway in program design while specifying the eligibility criteria essential to an effective, independent advocacy program. Although the clear intention is to develop a nationwide network of advocacy programs, the Committee felt that limited current resources should be made available on a competitive basis.

The Committee intends that the MHAP shall be coordinated closely with Legal Services Corporation programs. The Committee recognizes that mental health advocacy projects should involve more than legal assistance, and that many patients in need of mental health advocacy would not meet eligibility requirements for legal services. The Committee also recognizes that existing advocacy projects not funded by Legal Services Corporation, such as P&A systems which may want to expand their coverage to the mentally ill, should be able to compete for MHAP grants equally on the basis of merit.

In the Committee's view, there is a need to assess the performance of the full range of advocacy programs for all special needs groups. Section 305 requires the Comptroller General to conduct such a comprehensive study and to report back to the Congress prior to the expiration of the re-authorization of the Mental Health Systems Act. While the Committee recognizes that the Mental Health Advocacy Program established in Part B of this title will still be in its infancy during the period of the study, the Committee believes that comparative evalua-

tions of the early MHAP programs, other types of advocacy programs and the need for and impact of such efforts, will be valuable.

The Committee recognizes that, with respect to a number of groups—e.g., youth, racial and ethnic minorities, women, elderly individuals, chronically mentally ill individuals, former mental patients and others—whose rights have been abridged or who have been underserved by advocacy programs in the past, the process of formulating rights and fashioning effective advocacy programs is now going forward in many States and at the Federal level. The Committee does not intend, and would strongly disapprove of, any effort to defer appropriate legislative activity simply because of the GAO report requirement contained in this legislation.

Title IV

Section 401 of the Committee's bill provides for the designation of an Associate Director for Minority Concerns at the National Institute of Mental Health to develop and coordinate prevention, treatment, research, and administrative policies and programs to assure increased focus on minority populations. The Associate Director for Minority Concerns shall assist the Director in assuring the development, dissemination, and effective utilization of knowledge about the ability of our Nation's minorities to cope with and adapt to society's stresses. Considerable emphasis will be placed on evaluating the community mental health center programs' responsiveness to the prevention and service needs of minorities. The Associate Director for Minority Concerns will also actively explore the effects of racism, sexism, and ageism on mental health and aggressively promote research, training and service activities aimed at promoting mental health and preventing mental illness among minorities. This overall mandate is consistent with one of the specific recommendations contained in the President's Commission on Mental Health report.

The Committee created the position of Associate Director for minority concerns because it was concerned that NIMH has not adequately addressed the pervasive mental health needs of our nation's minorities despite the efforts within the NIMH of the Center for Minority Affairs to begin to systematically develop long-term strategies for addressing the unique problems of our nation's ethnic minority population. The Committee felt strongly that more should be done. Accordingly, NIMH is directed to provide the Associate Director for Minority Affairs with sufficient staff and programmatic resources to seriously address the service delivery, research, and manpower training issues. The Committee strongly recommends, in so doing, that priorities be developed, in consultation with representatives of the minority populations for each of these three important areas, and that these priorities be subsequently shared with the Committee for review.

The Committee is also aware of the special report on the Primary Health Care Needs of our Nation's Immigrants that was submitted to the Congress by the Secretary, in which it was expressly made clear that both our immigrants and refugee populations have serious mental health problems. These should be addressed by NIMH in conjunction

with the appropriate state/local public health authorities. This population should also be a priority for the Associate Director of Minority Affairs. Finally, in his annual report to the Congress, the Committee expects that the Associate Director shall include his specific recommendations for further legislation or administrative action as he deems appropriate, especially as to the possible needs to target and coordinate certain other HEW program initiatives on an experimental basis.

Title V

Section 501. Requires the Director of NIMH to designate an administrative unit focussing on the prevention of mental illness and the promotion of mental health. In addition, the Director is required to designate an individual to develop and coordinate the Institute's prevention and mental health promotion activities. This individual shall assist the Director in coordinating related training and research activities and in encouraging Federal, State and local activities relating to prevention and promotion, particularly those affecting children and adolescents.

The Committee included the provisions in this section because it intended that there be appropriate attention to the prevention of mental illness and the promotion of mental health in all relevant NIMH programs. There are preventive aspects of mental health service programs, of mental health research programs, of mental health training programs and of mental health education programs. The objective is to obtain increased attention to prevention/promotion in all these programs.

Currently there is little Federal leadership either in the development of national goals and priorities related to the prevention of mental illness or in stimulating interest at local and State levels or in other components of the Federal Government in the preventing of mental illness and the promotion of mental health. The Committee intends, in this section, to take significant steps to overcome these two deficiencies.

Title VI

Section 601. Extends the CMHC Act, specifying authorization levels for fiscal year 1981 for Sections 202(d), Planning grants; 203(d)(1) new Initial Operations grants; and 204(c) Consultation and Education grants. It also establishes an authorization level for fiscal year 1981 for Financial Distress grants. It terminates all authorizations for appropriations under the CMHC Act after September 30, 1982.

Section 602. Section authorizes appropriations under Title II of this Act for fiscal years 1982 through 1985. It repeals Section 237 of the CMHC Act, and Section 314(g) of the PHS Act, as of September 30, 1981, instead authorizing appropriations for fiscal years 1982 through 1985 for funds to assist the States in carrying out their responsibilities under this Act, for activities specified. This section further establishes authorization for funds to be appropriated for Title III for fiscal years 1982 through 1985.

Section 603 requires the Secretaries of Health and Human Services and Housing and Urban Development to jointly submit a report to

appropriate congressional committees relating to Federal efforts to respond to the shelter and basic living needs of chronically mentally ill individuals.

The Committee believes that meeting the needs of chronically mentally ill persons with respect to shelter and basic living services is critically important to the overall health and welfare of such individuals. While fully supporting the concept of deinstitutionalization, the Committee is aware of and deeply concerned about the plight of those chronically mentally ill persons who have been discharged in recent years from institutions without adequate provision being made for their shelter and living needs. Many of these people reside in settings which are inappropriate for their needs; others, more tragically, have no permanent housing arrangement whatsover and are forced to seek shelter in subways, parks and other inappropriate places.

Although the purpose of the Mental Health Systems Act is to provide funds for appropriate mental health and related support services, the Committee believes that the potential benefit of such services will not be fully realized if they are provided to individuals whose basic living needs are neglected.

The Committee is aware of the Demonstration Program for Deinstitutionalization of the Chronically Mentally Ill conducted jointly by the Departments of Housing and Urban Development and Health and Human Services and commends the Departments for undertaking this important initiative. This demonstration program, which is now in its third year, provides residential housing accommodations and services for chronically mentally ill persons.

The Committee believes, however, that in order to assure that the housing and basic living needs of chronically mentally ill individuals are met, permanent legislation must be enacted. To facilitate this process and benefit by the experience gained through the HUD/HHS demonstration program, the Committee included in S. 1177 the requirements of Sec. 603 which are designed to provide a thorough analysis of the shelter and basic living needs of chronically mentally ill persons and an evaluation of the HUD/HHS demonstration program.

Section 604 of the Committee's bill requires a report on the implementation of the Mental Health Systems. No later than January 1, 1985, the Secretary shall prepare and forward a report to the Committee on Labor and Human Resources of the United States Senate and the Committee on Interstate and Foreign Commerce of the United States House of Representatives. This report will focus on the implementation of the Mental Health Systems Act.

Specifically attention is directed to the number and types of application funded along with a description of the populations served as well as the services funded. This will offer a picture of the degree to which underserved and unserved populations are the recipients of services.

In addition, care should be given to assessing the extent to which the purposes of the Act have been reached, are being achieved and will continue to be achieved in the event the Act is extended. Part of the analysis will be directed to special problems in implementation at the local, State, or Federal levels so that corrective legislative action may be considered at a future date.

The report should also present recommendations regarding policy, design, requirements, criteria, and technical features of the Act which would improve the provision of mental health services, further prevention of mental illness, and promote mental health.

Their report should offer an opportunity for a systematic appraisal of the Act and, when appropriate, make it possible to modify through amendments these points, which when changed, will result in a realization of the purposes of the Act.

Section 605 of the Committee's bill includes an amendment to the Public Health Service Act that provides for the confidentiality of mental health records.

The Committee recognizes the need to assure the confidentiality and privacy of the treatment relationship in the field of mental health. It is an accepted premise that the capacity of a mental health professional to help his or her patient is strongly related to the patient's willingness to talk freely and openly. That willingness is in turn often dependent on the patient's belief that his or her communications are confidential.

The Committee realizes that it would be quite difficult to provide mental health treatment without being able to assure the patient of confidentiality, privacy, and indeed, privileged communication. The Committee believes that the treatment relationship is comparable to that of a priest/penitent or lawyer/client.

Patients not only disclose the very depths of their consciousness, but also their unconscious fears, feelings and attitudes. The Committee believes that confidentiality is a sine qua non for successful mental health treatment. Without a secure environment in which patients can communicate with the confidence that they are free from others knowing what may be said, all of mental health care would be destroyed.

Therefore, the Committee reaffirms its strong commitment to confidentiality, which it first demonstrated in the leadership role it took in 1974 with respect to the enactment of legislation to protect the confidentiality of drug and alcohol abuse patient records. The Committee believes that it is now appropriate to enact a similar law to protect mental health records.

As the Committee believes that confidentiality is essential to mental health treatment, the Committee, in addition to the coverage of this section, included a special right to confidentiality within that portion of the Committee bill referred to as the "bill of rights." It is the Committee's intent that those individuals covered under the "bill of rights" be able to protect the confidentiality of their records from unauthorized access and disclosure as provided in this section.

Section 605 of the Committee bill is based on the provisions of existing law for the confidentiality of drug and alcohol abuse patient records and the current regulations promulgated thereunder. The Committee believes that these laws and related regulations have and continue to be excellent models for protecting the rights of patients.

The Committee bill provides, as the general rule, that no records can be disclosed without the written, informed and voluntary consent of the patient.

The Committee realizes that in special limited cases, there are strong reasons to disclose certain information without the patient's consent.

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After careful consideration, the Committee has provided for seven narrowly-drawn exceptional situations where this can occur.

Title VII

Section 701 of the Committee's bill provided that the Secretary, through the National Center for the Prevention and Control of Rape (NCPCR), will fund grants and contracts to public and private organizations to develop and evaluate new methods of providing rape services.

The Secretary, through NCPCR, will fund grants and contracts for developing and evaluating projects for one or more of the following: (1) training programs for professional, paraprofessional, and volunteer personnel in law, social service, mental health, and other related fields providing services for rape victims and/or offenders; (2) treatment programs providing counseling for the victim, her/his immediate family, and/or the offenders; providing information about or referral to social services; providing consultation with allied professionals or follow up counseling for the victim, her/his family, and/or the offender; (3) community education; (4) offender rehabilitation and counseling; (5) self-help programs for victims as well as potential victims; (6) telephone systems (hot lines) to provide assistance to the victims; (7) emergency shelter programs; (8) projects focused on the development and evaluation of methods of preventing rape or on the addressing of social problems related to rape.

Under the Committee's bill all grants and contract applications must be submitted to and approved by the Secretary who shall determine the amount and method of payment. Each organization participating in such a program must establish record keeping systems to (1) protect the privacy of the victim or other individuals involved in the victimization, and (2) establish internal procedures for measuring progress in achieving stated goals.

The Committee expects the Secretary to coordinate these activities with others focused on rape elsewhere in HEW and in other agencies.

During hearings on S. 1177, testimony was heard with regard to the need to expand rape prevention and control programs. Legislation to provide Federal funding for services in this area (S. 621) had been introduced by Senator Mathias and was pending before the Subcommittee on Health and Scientific Research. S. 1177, as reported to the Senate, includes many of the major provisions of S. 621.

A rape is reported in the United States once every ten minutes according to the Federal Bureau of Investigation. Yet, many rapes are not reported. In 1976, the President's Commission on Law Enforcement and the Administration of Justice found that only one in three rapes were reported to the police. Authorities in the field estimate that the probability is one in fifteen that a woman will be raped in her lifetime. The crime of rape is the fastest growing of the FBI Uniform Crime Reports Index crimes against the person and among these it has the lowest proportion of cases closed by reason of arrest.

Although many physical injuries resulting from rape are minor, the psychological effects on the victim may be extremely severe. Rape produces severe and long-lasting emotional trauma and social dis-

ruption in the life of the rape victim and in that of her family. Moreover, services and support for victims of rape have been so seriously inadequate that many have characterized as "continued rape" the experience of the rape victim who reports the crime.

A variety of local entities have come into being to aid the rape victim. For example, the National Center for the Prevention and Control of Rape estimates there are 900 local rape crisis centers. These organizations are both private and public and vary in the range of services they provide. Many are totally volunteer efforts, often staffed by former rape victims, who provide victim referral and accompaniment to medical, legal and social services. The volunteers also provide counselling for the victim and her family. In addition, some hospitals working with law enforcement agencies and community groups, have established procedures in their emergency departments in order to combine good medical care and evidence collection with counselling and follow-up services.

Recognizing that there are a variety of settings in which services can be provided to victims of rape and that no comprehensive program of federal support exists at this time the Committee has included in S. 1177 a development and demonstration program to provide support for a wide range of efforts based in a wide range of public and private entities. The program is to be directed and administered by the National Center for the Prevention and Control of Rape.

The Committee expects that applications for support will come from local rape crisis centers, hospitals, migrant health centers, and community mental health centers. The services eligible for support are specified in the legislation and include training and treatment programs; grants for basic operating expenses such as telephone hot line: office space and utilities; victim accompaniment or referral to medical, social, mental health and legal services; counselling for the victim and her family; transportation costs associated with rape prevention and control programs; consultation with allied professionals and community education. The legislation also specifies activities involving rape prevention, social problems related to rape, and activities which focus on offenders.

S. 1177 also specifies that not more than 90 percent of the costs of a rape service project is to be funded by a grant or contract from the National Center for the Prevention and Control of Rape. This provision is designed to encourage a strong local commitment to the projects established, to build on the record of volunteer and community support which has characterized so many successful programs in this area, and to assure that funds from Federal agencies presently involved in rape related activities continue to be available.

Technical assistance is also authorized for those entities which desire to submit an application for support and which do not have the resources or expertise necessary to develop and submit an application without such assistance.

Provisions to protect the privacy of rape victims are also specified.

To assure prompt and thorough evaluation of the development and demonstration programs which are established, the Committee has required an annual report be submitted to the Congress including a summary of the activities funded and a review of the effectiveness

of those activities. The establishment of standards and outcome criteria is also required. The Committee intends to review these findings on a regular basis and expects that the findings will be an important element in future decisions as to the scope and need for a long-term rape service program.

The Committee has authorized up to ten additional full-time staff members to assist in carrying out the functions of the National Center for the Prevention and Control of Rape.

It is the intention of the Committee that funds authorized for the extension of existing programs shall also be available for use as part of development and demonstration projects which include research, dissemination of information, the development and distribution of training materials, or conferences and workshops.

IN CONCLUSION

From its study of the Community Health Centers Program to date, the Committee has drawn several conclusions, First, it is clear that the CMHC Act and the program operated under it has generally been a success in creating community alternatives to state inpatient facilities for mental health care. Approximately one-half of the nation is now served by CMHC's assisted with funds provided under the CMHC Act. The success of the program has led the Committee to conclude that the original intent of the CMHC Act—to provide funds with which to start centers throughout the nation—must be reaffirmed. In addition, the Committee wishes to reaffirm its strong belief that the existing mental health centers put in place under the CMHC Act must be maintained, strengthened and expanded. This will ensure that until health insurance covers the costs of care provided by these centers, high quality and comprehensive mental health services will continue to be offered in our communities.

V. Fiscal Impact Statement

In accordance with Section 252(a) of the Legislative Reorganization Act of 1970, as amended, cost estimates of the Committee's Bill are attached. The Committee appreciates the efforts of the Congressional Budget Office in preparing these cost estimates.

The Committee wishes to note that one must also consider existing law to understand fully the CBO estimates of authorizations and outlays. Presently, over $300 million per year are being spent on community mental health services. These sums are appropriated under existing statutory authorities which S. 1177 replaces. Therefore, the amounts listed in the CBO estimates for Fiscal Years 1981 and 1982, which do not consider current law, do not accurately reflect total mental health expenditures in those years.

U.S. Congress,
Congressional Budget Office,
Washington, D.C., May 9, 1980.

Hon. Harrison A. Williams, Jr.,
Chairman, Committee on Labor and Human Resources,
U.S. Senate, Washington, D.C.

Dear Mr. Chairman: Pursuant to Section 403 of the Congressional Budget Act of 1974, the Congressional Budget Office has prepared the attached cost estimate for S. 1177, the Mental Health Systems Act.

Should the Committee so desire, we would be pleased to provide further details on the attached cost estimate.

Sincerely,

Robert D. Reischauer
(For Alice M. Rivlin, Director).

Congressional Budget Office

cost estimate

May 9, 1980.

1. Bill number: S. 1177.
2. Bill title: Mental Health Systems Act.
3. Bill status: As ordered reported by the Senate Committee on Labor and Human Resources on April 24, 1980.
4. Bill purpose: S. 1177 would authorize the Secretary of Health and Human Services to contract with public and nonprofit private organizations, including designated state mental health services agencies, for the provision of a broad range of mental health services; authorize formula grants to states to assist them in planning, developing, and evaluating mental health services systems; establish in law the rights of persons seeking mental health services and authorize a Mental Health Advocacy Program to protect those rights; extend for fiscal

year 1981 the authorizations for planning grants, initial operating grants, grants for consultation and education services, and financial distress grants under the Community Mental Health Centers Act; authorize demonstration projects for the provision of rape services; and extend for three years the authorization for rape prevention and control activities under the Community Mental Health Centers Act.

5. Cost estimate:

[By fiscal years, in millions of dollars]

	1981	1982	1983	1984	1985
Authorization levels:					
Community services (sec. 602(a))		400.0	450.0	500.0	550.0
State formula grants [1] (sec. 602(b)(3))		20.0	22	24	26
Mental health advocacy [1] (sec. 602 (c))		10.0	11	12	13
Planning grants (CMHC Act, sec. 202(d))	1.0				
Initial operating grants (CMHC Act, sec. 203(d)(1))	42.0				
Consultation and education grants (CMHC Act, sec. 204(c))	19.0				
Financial distress grants (CMHC Act, sec. 213)	25.0				
Rape services demonstration projects (CMHC Act, sec. 232(k))	6.0	9.0	12.0		
National Center for the Prevention and Control of Rape (CMHC Act, sec. 232(1))	.200	.212	.224		
Rape prevention and control (CMHC Act, sec. 231(d))	10.2	11.5	13.0		
Total authorization levels	103.4	450.712	508.224	536.0	589.0
Estimated outlays:					
Community services		100.0	372.5	457.5	507.5
State formula grants		5.0	18.5	22.3	24.3
Mental health advocacy		2.5	9.25	11.15	12.15
Planning grants	.25	.65	.1		
Initial operating grants	10.5	27.3	4.2		
Consultation and education grants	4.75	12.35	1.9		
Financial distress grants	6.25	16.25	2.5		
Rape services demonstration projects	1.5	6.15	9.45	8.7	1.2
National Center for the Prevention and Control of Rape	.05	.18	.21	.17	.02
Rape prevention and control	2.55	9.50	11.75	9.6	1.3
Total, estimated outlays	25.85	179.88	430.36	509.42	546.47

[1] Authorization levels for fiscal years 1983, 1984, and 1985 are estimates made by CBO.

The costs of this bill fall within function 550.

6. Basis for estimate: Authorized amounts are assumed to be appropriated in full at the beginning of each fiscal year. Outlays are estimated using spendout rates computed by CBO on the basis of appropriate recent program data.

Authorization levels for fiscal years 1983, 1984, and 1985 under Sec. 602(b)(3) and Sec. 602(c) are assumed to increase from the levels specified for fiscal year 1982 according to CBO's projected rates of inflation.

7. Estimate comparison: None.

8. Previous CBO estimate: None.

9. Estimate prepared by: Malcolm J. Curtis.

10. Estimate approved by:

C. G. Nuckols
(For *James L. Blum*,
Assistant Director for Budget Analysis).

VI. Regulatory Impact Statement

Pursuant to Rule XXVI (11)(b) of the Standing Rules of the Senate, the following is an evaluation of the anticipated regulatory impact of S. 1177.

The bill extends for one year, through Fiscal Year 1981, the expiring authorizations of the Community Mental Health Centers Act. No new regulations will be required as a result of this one-year extension.

Beginning in Fiscal Year 1982, the Mental Health Systems Act initiates a new local-State-Federal partnership with respect to the planning, development, and provision of mental health services.

A. Estimate of number of regulated individuals and businesses

S. 1177 provides that, in those cases where a State Agency wishes to function as the exclusive contractor of mental health services in its State, the State must make a good faith effort to develop a program for regulating multi-occupant residences in which four or more chronically mentally ill individuals reside and for which board is charged, which program must deal with certain matters—access to visitors, fire safety, sanitation, etc.—designated in the Act. It is not possible to estimate the number of States which would seek to become exclusive contractors, and thus it is not possible to estimate the number of individuals and businesses which would be affected by this regulatory program.

The bill also extends certain rights to certain patients with regard to their treatment in certain mental health facilities and programs. All persons admitted on an ambulatory, residential, or inpatient care basis to an entity that provides mental health services and that either (1) directly provides inpatient services, (2) has a contractual arrangement allowing it to admit patients to another entity on an inpatient basis, or (3) receives funding under the Act; together with the mental health professionals at such settings; together with the facilities or programs themselves; would be affected by these rights and their enforcement.

B. Economic impact of regulation

To the extent that State Agencies which seek to function as exclusive contractors of mental health services in their States elect to develop programs for regulating multi-occupancy residences in which four or more chronically mentally ill individuals reside, individuals and businesses will incur costs related to this legislation. Since many states already have such programs, it is estimated that the costs will not be great. Certain of the requirements in question, e.g. access to visitors, will result in no or very few costs. Other requirements, e g. fire safety and sanitation, are already in place in many States, and to that extent will result in no additional economic burdens. Most significantly, the regulations required will very substantially from

State to State, and thus their economic impact cannot reasonably be predicted.

Similarly, it is not possible to make a realistic estimate of the bill of rights' economic impact. To the extent that it leads to more appropriate patient treatment, it will reduce operational costs. In those limited circumstances where it results in prolonged administrative disputes or litigation, it will add operational costs. How much costs will be decreased or increased, and what the net economic impact will be, cannot reasonably be predicted.

C. IMPACT ON PERSONAL PRIVACY

S. 1177 does not adversely affect the privacy of individuals. Rather, the bill includes in the patients' bill of rights a "right to confidentiality of . . . records, including confidentiality of information pertaining to . . . identity, diagnosis, prognosis, and treatment, under the same terms and conditions applicable . . . under section 515 of the Public Health Service Act." That provision, in turn, protects the confidentiality of mental health records in a manner similar to that which current law provides for the records of participants in Federally-funded alcohol and drug abuse programs.

D. PAPERWORK AND RECORDKEEPING IMPACT

The bill eliminates the overlapping planning requirements contained in section 314(g) of the Public Health Service Act and section 237 of the Community Health Centers Act by repealing those provisions and establishing a single set of planning requirements. State paperwork and recordkeeping should be reduced accordingly.

The bill's paperwork requirements are otherwise of the normal kind: as with applicants for Federal funding today under the Community Mental Health Centers Act, applicants for funding under this Act would have to submit written applications to the Department of Health and Human Services; accepted applications would then be transformed through negotiation into written performance contracts; recipients of funding would of course be required to make reports relating to performance.

No recordkeeping requirement other than the kind now in effect for community mental health centers is imposed.

VII. Tabulation of Votes Cast in Committee

Pursuant to Section 133(b) of the Legislative Reorganization Act of 1946, the following is a tabulation of votes cast in committee on S. 1177.

The bill was considered in open executive session on October 18, 1979, by the Subcommittee on Health and Scientific Research. An amendment to add a mental patients' bill of rights and advocacy program was submitted by Senator Javits on behalf of himself and Senators Kennedy, Williams, Cranston, Schweiker, Metzenbaum, Pell, and Hatch. Senator Kennedy moved that S. 1177, as amended by Senator Javits' amendment and other amendments of a substantive and technical nature, be reported to the Committee on Labor and Human Resources. The motion carried by a vote of 9–0, as follows:

Ayes	*Nays*
Senator Kennedy	
Senator Williams	
Senator Pell	
Senator Cranston	
Senator Metzenbaum	
Senator Schweiker	
Senator Javits	
Senator Hatch	
Senator Humphrey	

The bill, as thus amended, was considered in open executive session on April 24, 1980, by the Committee on Labor and Human Resources. Senator Williams moved that S. 1177, as further amended by a substitute amendment containing a variety of substantive and technical amendments, be reported to the Senate. The motion carried by a vote of 11–1, as follows:

Ayes	*Nays*
Senator Williams	Senator Armstrong
Senator Randolph	
Senator Pell	
Senator Kennedy	
Senator Nelson	
Senator Cranston	
Senator Riegle	
Senator Metzenbaum	
Senator Schweiker	
Senator Javits	
Senator Stafford	

VIII. Section-by-Section Analysis of S. 1177

S. 1177, a bill "To improve the the provision of mental health services and otherwise promote mental health throughout the United States."

Section 1. Short Title.—Provides that the Act may be cited as the "Mental Health Systems Act" and sets forth a table of contents.

Section 2. Findings and Purpose.—Subsection (a) sets forth eight findings: (1) despite improved and more available mental health services since the enactment of the Community Mental Health Centers Act, many individuals remain unserved or underserved, including in particular many chronically mentally ill individuals, racial or ethnic minorities, women, poor persons, and persons residing in rural areas; (2) as chronically mentally ill people have been deinstitutionalized and returned to their home communities, the mental health and support services needed by these individuals has frequently not been provided in community settings, and training, retraining and job placement have frequently not been provided for employees of the affected institutions; (3) the delivery of mental health and support services is often uncoordinated at and among various governmental levels; (4) mentally ill persons often are inadequately served by Federal programs of the Departments of Health and Human Services, Housing and Urban Development, Labor, and other Federal agencies; (5) health care systems often lack both general health care personnel with adequate mental health training and mental health care personnel; (6) efforts to prevent mental illness through discovery and elimination of its causes and through early detection and treatment are too limited; (7) a comprehensive and coordinated array of appropriate private and public sector mental health and support services for all persons in need within a specific geographic area, based upon a cooperative local/State/Federal parnership, remains the most effective and humane way to provide a majority of mentally ill individuals with mental health care and needed support; and (8) psychiatry is a medical shortage specialty, and there are distinct needs for clinical psychologists, psychiatric nurses, and psychiatric social workers.

Subsection (b) sets forth six purposes of the Act: (1) to provide and assure an appropriate coordinated, and accountable network of comprehensive community-based mental health services for all persons in need; (2) to improve and initiate mental health and support services for unserved and underserved populations, including those populations specifically mentioned in the findings; (3) to encourage innovative programs for prevention of mental illness and promotion of mental health; (4) to provide more flexibility in the funding of mental health services and encourage development of a partnership among all levels of government in delivering services; (5) to facilitate State efforts to carry out the State's responsibility for: providing or arranging for the provision of care to chronically mentally ill adults and

children; effecting a transition from an institution-based service system to a community-based service system, including the provision of training, retraining, and job placement for employees of affected institutions; coordinating mental health services provided in the State with related support services provided in the State; ensuring the adequacy and fiscal soundness of all mental health and support services within a State through the mental health planning process; and promoting the coordinated delivery of and planning for mental health and support services at and among all levels of activity and governments; and (6) to promote evaluation of the mental health delivery system, particularly with regard to its effectiveness in meeting the needs of priority population groups.

Section 3. Definitions.—Defines terms used in the Act. Several terms ("state", "Governor", "Secretary", and "non-profit") are defined in the customary manner. "Mental health service area" means a geographic area established for the purpose of planning and providing mental health services. "State health plan" means the plan prepared in accordance with title XV of the Public Health Service Act. "Mental health services" means treatment which reasonably can be expected to ameliorate a nervous, mental, or emotional disorder, or which reasonably can be expected to prevent the decline of or improve a person's level of mental functioning. "Support services" means health services other than mental health services, and the educational, rehabilitation, vocational, housing and social services and other services specified by the Secretary. "Priority population group" means any group determined by the Secretary to have special mental needs and to be unserved or underserved by mental health service programs. Specifically included are chronically mentally ill individuals, children and youth, elderly persons, any racial or ethnic minority, Indians and urban Indians, Native Hawaiians, the poor, rural residents, and victims of violence or disaster. "Comprehensive mental health services" mean the services described in section 201(b) of the Community Mental Health Centers Act. (These are inpatient, outpatient, and emergency services, screening, followup care, consultation and education services, day care, specialized services for the mental health of children and of the elderly, transitional half-way house services, and alcohol and drug abuse prevention and treatment services.) "Community mental health center" means an entity which provides comprehensive mental health services, as defined. "Contract" means a cooperative agreement as described in section 6 of the Federal Grant and Cooperative Agreement Act of 1977 (which provides that each executive agency use a cooperative agreement as the legal instrument reflecting a relationship between the Federal government and a State and local government or other recipient whenever "substantial involvement" is anticipated between the executive agency and the recipient during performance of the contemplated activity).

TITLE I—STATE HEALTH SYSTEM

Section 101. Condition of Federal Funding.—Provides that for any entity in a State to receive funding under this Act the State must meet the requirements of Title I.

Section 102. Designation and function of State Agencies.—Provides that each State shall designate a "State Agency" as its administrative agency with regard to mental health services. The State Agency shall divide the State into mental health service areas and prepare, consistent with the mental health provisions of the State health plan, a State mental health operations program.

Section 103. Mental Health Service Areas.—Provides that each designated State Agency, within one year after the effective date of the Act, shall divide the State into mental health service areas appropriate for the development, delivery and coordination of mental health services. Designations shall follow public hearings and shall be based on a consideration of the optimum number of persons to be served in each area, the accessibility of services to persons in each area, the cultural needs of persons residing in the area, and preexisting geographic boundaries related to the provision of mental health and other services. Further, the boundaries of each mental health service area must be within or conform to the boundaries of a health service area established pursuant to Title XV of the Public Health Service Act.

Section 104. Mental Health Provisions of the State Health Plan.—Requires that each State health plan prepared pursuant to title XV of the Public Health Service Act shall contain provisions relating to: the need for mental health services in the State; the special mental health needs of chronically mentally ill persons, emotionally disturbed children and adolescents, and other priority population groups; the adequacy of mental health facilities and services available in the State; State mental health service priorities; mental health service delivery barriers in the State; the coordination of mental health with health and other services; measures to assure confidentiality of records; and such other requirements as the Secretary may prescribe to carry out the provisions of title XV of the Public Health Service Act and of this Act.

Section 105. Mental Health Operations Program—Subsection (a) provides that each State Agency shall prepare, consistent with the mental health provisions of the State health plan and after consultation with the Statewide Health Coordinating Council established pursuant to title XV of the Public Health Service Act, a mental health operations program.

Subsection (b) provides that this program shall: identify the mental health service areas within the State; identify each mental health service area's needs for mental health and related support services; identify the special mental health service needs of chronically mentally ill individuals, emotionally disturbed children and adolescents, elderly individuals, and other priority populations; identify and evaluate the mental health facilities, personnel, and services available in each mental health service area and determine what additional facilities, personnel, and services are needed; identify the methods used to determine mental health needs and evaluate resources; list mental health service needs of each mental health service area in the order of priority to be addressed through the use of existing resources; identify measures to reduce barriers to the delivery of mental health services; identify measures needed to be taken to assure that services will be provided with attention to continuity and quality of care and human

dignity; identify legal rights of mentally ill persons and measures needed to protect their rights; and identify the measures which need to be taken to coordinate the provision of mental health services, including mental health and support services for chronically mentally ill persons and other priority population groups.

Subsection (c) provides that the mental health operations programs shall also describe in specific terms how the State Agency will: ensure the continued provision of appropriate services provided in the past by entities which once received Federal funding under the Community Mental Health Centers Act or this Act but are no longer eligible for Federal funding under this Act; promote the development of comprehensive mental health services where such services are currently unavailable; ensure within a five-year period after the program is prepared (unless that period is extended by the Secretary) that: residents of public inpatient psychiatric facilities who were inappropriately placed in such facilities are identified, discharged, and, to the extent appropriate, placed in the least restrictive settings and provided mental health and support services appropriate to their level of functioning; persons who need to be placed in mental health facilities are also placed in least restrictive settings and provided with appropriate mental health and support services; and persons who are discharged from or are in need of placement in mental health facilities shall upon discharge or prior to placement be informed of available community-based facilities and programs providing mental health and related support services and have access to a sufficient number of adequately staffed and adequately funded community-based facilities and programs. The mental health operations program will also describe how the State Agency will: promote the development of adequate mental health services for chronically mentally ill individuals and other priority population groups; promote the prevention of mental illness; assist in screening persons being considered for inpatient care in mental health facilities to determine if such care is medically or psychologically indicated; comply with regulations prescribed by the Secretary of Labor pertaining to training, retraining, and placement of employees adversely affected by the deinstitutionalization process; and make adequate provisions for the development of planning and service delivery staffs with appropriate training and experience.

Subsection (d) provides that the mental health operations program shall describe the financial commitment and the ability of the State to implement the program, include an analysis of the services made available for mentally ill individuals in the State under other relevant Federal programs, and describe the actions being taken by the State to coordinate the provision of services under this Act with the provision of services under these other programs.

Subsection (e) requires that, in preparing the mental health operations programs, the State Agency shall consult with a State advisory council which is representative of consumers and providers of mental health services in the State, of nongovernmental organizations or groups, and of State agencies. Consumer representatives shall constitute a majority of the members of the council.

Section 106. Enforcement.—Provides that whenever the Secretary determines that there has been a substantial and persistent failure to

comply with the requirements of this title, the Secretary will notify the State Agency that further payments under this Act will not be made to any entity in the State, including the State Agency, until the Secretary is satisfied that this failure has been or will be corrected. After providing this notice and the opportunity for an informal hearing in the State, if the Secretary reaffirms the determination of noncompliance, no further payments will be made under this Act until the Secretary is satisfied that this failure has been or will be corrected. The Secretary may, however, continue to make payments to an entity which received funding under the Community Mental Health Centers Act prior to October 1, 1979 if the Secretary determines that such entity in no way contributed to the failure to comply and that payments have been terminated for at least one month.

TITLE II—COMMUNITY SERVICES

Part A—Contract Authority

Section 201. Contracts.—Provides that the Secretary may enter into contracts with public and nonprofit private entities, including State Agencies, to provide the services described in Part B of this title and that the requirements in other parts of this title are controlling with respect to any contract entered into and its amount.

Part B—Types of Services

Section 202. Services for Chronically Mentally Ill Individuals.—Subsection (a) provides that the Secretary may enter into contracts with public and nonprofit private entities other than State Agencies for the provision of mental health and related support services to chronically mentally ill individuals. Such a contract shall provide for at least one of the following services: identifying and providing outreach to chronically mentally ill individuals in community or inpatient facilities, and identifying the barriers preventing such individuals from receiving needed services and devising and implementing measures to eliminate such barriers; making case managers available to such individuals to assume responsibility for coordinating the provision of mental health services and related support services as needed, and assuring the provision of outreach to their families and employers; and developing, in collaboration with other health, mental health, and human service agencies, community support services (such as assistance in applying for entitlements) in order to reduce the dependency and increase the potential of individuals receiving such services.

Subsection (b) provides that the Secretary may enter into contracts with State Agencies for the provision of mental health and related support services to chronically mentally ill individuals, provided that each contract provides for at least one of the following: assisting mental health service areas in identifying chronically mentally ill individuals in need of services, and planning and carrying out the provision of such services; assessing the needs of chronically mentally ill individuals throughout the State, identifying barriers preventing the receipt of services, and devising and implementing measures to eliminate these barriers; improving the skills of personnel providing services to chronically mentally ill individuals; providing or arranging for the

provision of training, retraining, and job placement for employees of public inpatient psychiatric facilities at which there has been a reduction in the need for such employees, so that they can be placed in community settings; and coordinating the operations of State agencies or intrastate regional agencies responsible for mental health and related support services for chronically mentally ill individuals, and coordinating the provision of mental health and support services with the provision of other services made available under other Federal acts providing health and social services.

Section 203. Services for Severely Disturbed Children and Adolescents.—Provides that the Secretary may enter into contracts with public and nonprofit private entities for the provision of mental health and related support services to severely disturbed children and adolescents, provided that at least one of the following services is provided: identifying severely disturbed children and adolescents, assessing their needs, and providing unmet services; assuring the availability of appropriate personnel to provide or arrange for the provision of needed services; coordinating the provision of mental health and related support services available to severely disturbed children and adolescents with the activities of community agencies and State agencies and the provision of services available pursuant to other Federal programs; establishing cooperative arrangements with juvenile justice authorities, educational authorities and other agencies in contact with severely disturbed children and adolescents to ensure referral to appropriate mental health and related support services; establishing self-help groups and crisis support programs for children and adolescents and their families; and provising auxiliary mental health services to handicapped children served under the Education for All Handicapped Children Act.

Section 204. Services for Elderly Individuals.—Provides that the Secretary may enter into contracts with public and nonprofit entities for the provision of mental health and support services to elderly individuals, provided that outreach and at least one of the following services are provided; identifying and assessing mental health needs of elderly individuals and providing needed services; assuring the availability of appropriate personnel to provide or arrange for the provision of needed mental health and related support services; coordinating the provision of mental health and related support services available to elderly individuals with the activities of the area agency on aging (as defined in the Older Americans Act) and other community agencies providing mental health and support services and with the provision of services available under other Federal programs; providing mental health services to elderly individuals in, and staff training for employees of, nursing homes, intermediate care facilities, boarding homes, senior centers, and ongoing self-help groups and crisis support programs; and providing medical differential diagnoses to distinguish individuals' needs for mental health services and medical care.

Section 205. Services for Priority Population Groups.—Provides that the Secretary may enter into contracts with public and nonprofit private entities for the provision of mental health and support serv-

ices to priority population groups other than chornically mentally ill individuals, severely disturbed children and adolescents, and elderly individuals. Such contracts shall promote comprehensive mental health services, where appropriate, for such priority population groups.

Section 206. Prevention of Mental Illness and Promotion of Mental Health.—Provides that the Secretary may enter into contracts with public and nonprofit private entities for programs to prevent mental illness and promote mental health. Such contracts shall focus upon population groups at highest risk of mental illness. Programs supported under this section must be consistent with national goals and priorities regarding the prevention of mental illness and promotion of mental health determined by the Director of the National Institute of Mental Health. Contracts may be entered into for a variety of purposes including: to educate the general public regarding mental health problems and mental illness, prevention of mental health problems and mental illness, and promotion of mental health; to improve the ability of health and human services personnel to identify mental illness and assure appropriate care; to provide screening, consultation, referral and education in public school systems and in the workplace; to organize self-help groups for populations at high risk; and to promote measures to manage and reduce stress.

Section 207. Community Mental Health Centers.—Subsection (a) provides that the Secretary may enter into contracts with public and nonprofit private entities for the provision of comprehensive mental health services by a community mental health center.

Subsection (b) provides that a community mental health center which provides services pursuant to this section must comply with all applicable provisions of the Community Mental Health Centers Act and shall also establish, in accordance with regulations prescribed by the Secretary, a quality assurance program which includes multidisciplinary peer review and utilization evaluation, a secure system of recordkeeping which is in accord with Federal and State laws respecting confidentiality of and access to such records, a multidisciplinary professional advisory board, and an identifiable administrative unit responsible for providing consultation and education services.

Subsection (c) requires that the provision of services by a community mental health center shall be coordinated with the provision of services by other mental health and social service programs and agencies serving residents of the mental health service area. Services may be provided at a community mental health center or a satellite facility located in the mental health service area, by the staff of the community mental health center or through arrangements with other health professionals and other providers located in the mental health service area, and, in the case only of inpatient, emergency, or partial hospitalization services, or certain specialized services, by health professionals or agencies, pursuant to appropriate arrangements, in any location that is readily accessible to residents of the mental health service area.

Subsection (d) requires that all services provided under this section be accessible and promptly available to all residents of the mental health service area, assure continuity and quality of care, and take

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into account the cultural, economic and social characteristics of the population to be served.

Section 208. Non-revenue Producing Services.—Provides that the Secretary may enter into contracts with public and nonprofit entities for the provision of non-revenue producing services. Such services must be provided by an existing community mental health center if one exists in the mental health service area. Services provided under this section may include consultation and educational services, evaluation, case management, and any other non-revenue producing service determined to be appropriate by the Secretary.

Section 209. Linkages Between Health Care Settings and Mental Health Services.—Provides that the Secretary may enter into contracts with any public or nonprofit private entity providing mental health services or having in effect a written agreement with another entity providing mental health services to ensure linkages between health facilities and programs, nursing homes, and intermediate care facilities and mental health facilities and programs. A contract entered into under this section shall identify individuals in need of mental health services in health care facilities, nursing homes, and intermediate care facilities and provide or arrange for the provision of mental health and related support services for such individuals.

Part C—Application Requirements

Section 210. Application Requirements.—Subsection (a) provides that an application for a contract under this title may omit any service or requirement if that service or requirement is already being provided or met and the application demonstrates this fact to the satisfaction of the Secretary.

Subsection (b) provides that an application shall contain or be accompanied by: a statement of the objectives of the services to be provided; information regarding the organization and operation of the entity submitting the application; a financing plan and budget; the schedule of fees to be charged for services; including discounts to be allowed to individuals unable to pay in full; assurances that Federal funds made available under this Act will be used to supplement and not supplant non-Federal funds; assurances that members of the group or groups to be served, members of the public, and affected organizations and agencies have been consulted in the development of the application; a description, where substantial portions of the population to be served are of limited English-speaking ability or are bicultural, or both, of how the entity will provide services in appropriate languages and cultural contexts, and the extent to which staff will be bilingual and bicultural; a description of the efforts made and to be made to coordinate the services to be provided with other mental health and support services in the same area; assurances of applicant eligibility; information regarding past and proposed services for chronically mentally ill individuals; assurances that the applicant will submit such reports and maintain such records as the Secretary may request, and afford the Secretary and the Comptroller General of the United States access to relevant documents for audit activities; statistics and other information requested by the Secretary necessary to evaluate the compliance with the requirements of this Act; and such

other information, materials and assurances as the Secretary may prescribe.

Part D—Applicant Eligibility

Section 211. Eligibility Requirements: In General.—Subsection 211 (a) requires that any entity, other than a public entity or a hospital, which seeks to provide comprehensive services through a community mental health center pursuant to Sec. 207, or which has as its primary purpose the provision of services which are funded under this Act, must provide satisfactory assurances to the Secretary that it has a governing board which is composed, where practicable, of individuals who reside in the entity's mental health service area and who as a group represent the residents of that area, taking into consideration their employment, age, sex, place of residence, and other demographic characteristics of the area. At least one-half of the members of such board must be individuals who are not providers of health care. The board must meet at least once a month, establish general policies for the entity, approve the entity's annual budget, and approve the selection of its director. Public entities or hospitals may in lieu of this requirement have an advisory committee composed of individuals who reside in the entity's mental health service area and who are representative of the residents of the area, provided that at least one-half of the members of this committee are not providers of health care. The committee will advise the entity with respect to the provision of services funded under this Act. Certain entities (i.e. hospital—affiliated primary care centers, migrant health centers, and community health centers) are exempted because of their compliance with parallel Federal requirements.

Subsection (b) provides that, to be eligible to enter into a contract to provide services pursuant to section 202–206 or 209 in any mental health service area, an entity other than a State Agency must provide satisfactory assurances to the Secretary that it has negotiated in good faith regarding, or secured, a contract or agreement with any entity providing comprehensive mental health services through a community mental health center in the mental health service area concerning their mutual responsibilities. In the case of the State Agency, it must provide assurances satisfactory to the Secretary that it has made a good faith effort to coordinate, or has coordinated, with any entity providing comprehensive mental health services through a community mental health center in the mental health service area concerning their mutual responsibility. To be eligible to enter into a contract to provide services pursuant to sections 207 and 208, an entity other than a State Agency must provide satisfactory assurances to the Secretary that it has negotiated in good faith regarding, or secured, a contract or agreement with any other entity providing mental health services in the mental health service area. In the case of a State Agency, it must provide satisfactory assurances to the Secretary that it has made a good faith effort to coordinate, or has coordinated, with any other entity providing mental health services in the mental health service area.

Subsection (c) provides that to be eligible to enter into a contract under this title an entity must provide satisfactory assurances to the Secretary that its application is consistent with the State health plan of the State.

Section 212. Eligibility Requirements for State Agencies.—Subsection (a) provides that to be eligible to enter into a contract under this title a State Agency shall provide satisfactory assurances to the Secretary that local public and nonprofit private entities have been included as providers of service to the maximum extent possible.

Subsection (a) provides that a State Agency must be certified to be in compliance with regulations of the Secretary of Labor which require fair and equitable arrangements to protect the interest of employees adversely affected by actions taken to emphasize outpatient treatment of mentally ill individuals against a worsening of such employees' positions with respect to their employment. The Secretary of Labor shall certify which States which have applied for funding under this title are in compliance with these regulations and shall provide the Secretary of Health and Human Services with a list of States so certified.

Section 213. Eligibility Requirements for State Agencies Seeking to be Exclusive Contractors.—Subsection (a) provides that a State Agency may be the exclusive contractor of services for a State under this title if it complies with the provisions of this section and the Secretary enters into an exclusive contract with it under section 217.

Subsection (b) provides that the State Agency, to be eligible to enter into a contract to be the exclusive contractor of services for a State under this title, must demonstrate to the satisfaction of the Secretary that it is effectively implementing is mental health operations program prepared pursuant to section 105 and that it is making a good faith effort to establish and implement procedures for carrying out the requirements of subsection (c) of this section.

Subsection (c) sets forth additional requirements for a State Agency to be the exclusive contractor. The State Agency must monitor the placement in the community of chronically mentally ill individuals discharged or diverted from mental health facilities, and prevent overconcentration of such individuals in any community or group of communities. It must administer a program of support and placement services for chronically mentally ill individuals in the State which prescribes and enforces minimum standards for the provision of followup care for such individuals by community mental health centers and other appropriate entities. This program must include as a minimum: timely notification by the mental health facility to the appropriate community mental health center or other entity concerning the discharge of each chronically mentally ill individual and the placement of such individual in the mental health service area; a prerelease consultation between the mental health facility and the appropriate community facility, including a preliminary evaluation of the physical, mental, social and monetary needs of the individual to be discharged and an identification of the services and programs for which such individual is eligible; and development by the mental health facility of a written treatment and services plan for each individual to be discharged, in consultation with a case manager in the community facility. This plan shall to the maximum extent feasible be developed with the participation of the individual and his or her family, include appropriate living arrangements suited to the individual's need, describe appropriate mental health services and other needed

health and social services, identify specific programs and services for which the individual is eligible and provide for a periodic reevaluation of the plan at least every 120 days.

The State Agency's program shall also include designation of a case manager responsible for the coordination of services for, and the implementation of the treatment and services plan of, each individual discharged or diverted. To be in compliance with this section a State Agency must also develop a program for regulating certain multioccupant residences in which four or more unrelated chronically mentally ill individuals reside and for which room is charged, in accordance with guidelines established by the Secretary. Such program must include: minimum standards for approval of a residence; evaluation, inspection, and monitoring procedures; and remedies for noncompliance. The State Agency must further: provide educational or informational services to educate the population of the State regarding the problems of mentally ill individuals and the need for community involvement; improve the skills of personnel involved in providing services for chronically mentally ill individuals; and review State policies and programs to determine if they discriminate against chronically mentally ill individuals and, if so, the means by which such discrimination may be eliminated.

Subsection (d) provides that a State must provide satisfactory assurances to the Secretary that it will submit an annual report to the Secretary regarding its efforts and progress under this section, including the State's progress in ensuring that, as chronically mentally ill individuals are discharged from State mental health facilities, State mental health funds are flowing from institution-based care to community-based care.

Section 214. Process for Determining Eligibility of State Agencies to be Exclusive Contractors.—No later than 330 days before the beginning of each fiscal year the Secretary shall determine and announce which State agencies have met the requirements of section 213 and are eligible to be exclusive contractors of services for their States under this title. Prior to that date the Secretary shall provide technical assistance to State agencies which seek to meet but do not meet such requirements.

Part E—Application Procedure, Selection of Applications, Performance Contracts

Section 215. Application Procedure.—Subsection (a) provides that all applications by public and nonprofit entities to enter into contracts under this title must be submitted to the State Agency no later than 270 days prior to the first day of the fiscal year for which funding is sought. Prior to submission to the State Agency, each application must be submitted to the appropriate health systems agency (HSA) established pursuant to title XV of the Public Health Service Act, which may submit recommendations and comments to the State Agency at any time prior to the transmission of applications by the State Agency to the Secretary.

Subsection (b) provides that the State Agency may itself prepare one or more non-exclusive applications to enter into contracts under this title or, if it has been determined to be eligible to be the exclusive contractor of services for the State pursuant to section 214, prepare

an application to be the exclusive contractor of services. If the State Agency prepares one or more non-exclusive applications, the State Agency must submit these applications to the affected health systems agencies no later than 270 days prior to the first day of the fiscal year for which funding is sought. The HSAs may, as with other applications, submit comments and recommendations regarding such applications to the State Agency at any time prior to the transmission of such applications to the Secretary. If a State which is eligible to be the exclusive contractor of services decides that it will submit an application for such purposes it shall announce such decision no later than 270 days prior to the first day of the fiscal year for which funding is sought. The application to be an exclusive contractor shall be submitted not to the HSAs but to the Statewide Health Coordinating Council (SHCC) for the State, established pursuant to title XV of the Public Health Service Act.

Subsection (c) provides that, within 45 days after the final date of submission of applications, the State Agency shall provide public notice of all applications submitted, the comments and recommendations, if any, submitted by the health systems agencies, and the comments and recommendations, if any, of the State Agency. If the State has chosen to submit an application to be the exclusive contractor of mental health services for the State it must provide public notice of the application to be submitted to the Secretary and the comments and recommendations, if any, of the SHCC.

Subsection (d) provides that no sooner than 20 days but no later than 30 days after the date public notice is provided under subsection (c) the State Agency must convene public hearings and receive public comment.

Subsection (e) provides that after consideration of the public comments the State Agency, on the date 150 days prior to the first day of the fiscal year for which funding is sought, shall transmit to the Secretary either (1) the applications submitted by local entities and its own non-exclusive applications, the comments and recommendations, if any, of the health systems agencies and the State Agency, and the comments and recommendations, if any, received pursuant to the public hearings, or (2) the State Agency's exclusive application. and the comments and recommendations, if any, of the SHCC and the public.

Subsection (f) provides that an application transmitted by a State Agency to be the exclusive contractor of mental health services may omit any application submitted by any other entity and incorporate any one or more of the following: applications submitted by other entities in substantially their original form; applications submitted by other entities but substantially modified by the State Agency; and services under this title proposed only by the State Agency.

Subsection (g) provides that whenever a State Agency transmits an application to be the exclusive contractor and such application omits an application submitted by an entity to the State Agency or incorporates such an application in a substantially modified form, the State Agency must inform the entity that submitted the application of the omission or modification and provide the reasons for such action.

The entity may within 30 days after receipt of notice from the State agency request that the application or modified portions of it be considered in the original form during the negotiation between the State Agency and the Secretary. This request must be accompanied by written justification. The Secretary must promptly determine if the application or modified portions of it are consistent with the State health plan of the State and if the entity has sought to or had an opportunity to make a good faith effort to negotiate with the State Agency regarding the incorporation of the application or the modified portions of it. If the Secretary determines that these requirements have been met, the Secretary shall review the justifications submitted by the agency for incorporation and the justifications of the State agency regarding omission or modification. If the Secretary determines that an entity's justifications for incorporation of its application or portions are as meritorious as the State Agency's justifications for omission or with the provisions of this Act, is inconsistent with the State health plan, or was made in an arbitrary or capricious manner, the entity's application or portions shall be considered during the negotation of the State Agency's application between the State Agency and the Secretary.

Subsection (h) provides that the State Agency shall make available to any interested party 150 days before the beginning of the fiscal year for which funding is sought the materials transmitted to the Secretary.

Subsection (i) provides that should the State Agency fail to transmit the appropriate materials to the Secretary as required by subsection (e), any entity that has submitted an application may transmit that application directly to the Secretary.

Subsection (j) provides that if a State Agency transmits an application to be the exclusive contractor, the State Agency and the Secretary shall select two citizen representatives to provide advice during the negotiation of the application between the State Agency and the Secretary. Organizations representing consumers of mental health services within a State and organizations representing local providers of mental health services within a State may recommend to the State Agency and the Secretary the names of individuals to serve as representatives. On the basis of these recommendations the State Agency and the Secretary shall agree upon one representative of the consumers and one representative of the providers.

Section 216. Selection of Applications.—Subsection (a) provides that the Secretary, after conducting negotiations with the entities that originally submitted the applications transmitted to the Secretary or with the State Agency regarding its application to be the exclusive contractor of mental health services for the State, shall select those applications that: are consistent with the State health plan; are consistent with the applicable provisions of this title; and are most likely in the Secretary's judgment to provide priority population groups with the most effective and broadest services, provide the general population with the most effective and broadest services, lead to the provision of comprehensive mental health services for all persons in every mental health service area, provide for the maximum feasible utilization of private and public non-Federal resources, and where appropriate provide services in appropriate languages and cultural contexts and provide staff that is bilingual and bicultural.

Subsection (b) requires that the Secretary shall provide an explanation to each entity whose application was transmitted to the Secretary of the reasons for acceptance or rejection. If the Secretary uses a formula to rank applications, the Secretary shall provide notice of the principles upon which that formula is based. The explanation provided to the entity must include an explanation of the designated rank of such entity's application.

Section 217. Performance Contracts.—Subsection (a) provides that any entity whose application to provide services is selected is eligible to enter into an annual performance contract with the Secretary. A State Agency selected to be the exclusive contractor of mental health services for a State shall enter performance contracts with other entities providing services in the States as subcontractors.

Subsection (b) requires that each performance contract shall include agreements regarding: the establishment of citizen participation in the administration of services; the populations to be served, the settings in which services are to be delivered, the means by which such settings shall be the least restrictive and most accessible, and the anticipated outcome and service impact on the populations to be served; the standards and methods by which performance will be monitored and evaluated; the methods and format by which performance data will be collected and transmitted to the Secretary; the qualifications, functions, and responsibility of personnel; the annual budget; coordination of the entity's activities with the activities of other entities providing mental health services or related support services; the allocation of responsibilities among local, State, and Federal entities; the means by which the entity will decrease its reliance on Federal financial support under this Act; a schedule for the performance of all obligations arising under the performance contract; an expeditious and impartial method to resolve disputes arising under the performance contract; remedies in the event that a contracting party fails to carry out an obligation arising under the contract; and such other matters as the Secretary determines shall be negotiated and resolved.

Subsection (c) provides that the Secretary shall promulgate regulations establishing criteria with respect to the evaluation of the performance of entities under this Act.

Section 218. Enforcement.—Provides that no entity may receive funds under this title unless it has entered into a performance contract which complies with the requirements of section 217. This section further provides that the Secretary shall periodically review the performance of the entity. Substantial and unreasonable failure to perform in accordance with the performance contract or to cooperate with other entities providing mental health or support services shall, after notice of alleged failure and an opportunity for informal hearing which results in a finding of such failure, be a reasonable justification for terminating funding under this title.

Section 219. Funding for Innovative Projects.—Provides that a public or nonprofit private entity, or other private entity engaged solely in the provision of services related to mental health, may submit directly to the Secretary an application to provide services under this title, if such entity determines that the services to be provided are

innovative and of national significance. The Secretary may enter into contracts for such services if the Secretary determines that they are innovative and of national significance. No more than five percent of the funds available for allocation under this title may be used for contracts under this section. Entities receiving funding under this section will be subject to the requirements of sections 217 and 218.

Part F—General Provisions

Section 220. Duration of Contracts.—Provides that a contract shall be for such period of time not exceeding one year as the Secretary may determine.

Section 221. Indirect Provisions of Services.—Provides that services may be provided directly by the contracting entity at its primary or satellite facilities or by arrangements with other entities or health professionals.

Section 222. Payment Procedures.—Subsection (a) provides that payments for any fiscal year may be reduced to the extent that the sums paid to the entity under any prior contract under the same section of this title, or sums paid under certain sections of the Community Mental Health Centers Act, plus funds available from State, local, or other sources, exceed the total cost of the project, in lieu of such excess being repaid to the United States.

Subsection (b) provides that in the case of any excess such portion as the Secretary may determine, but not exceeding five percent of the cost of operation of the recipient's mental health program, may be retained by the recipient for deposit in a reserve fund maintained for purposes approved by the Secretary, and shall not be counted as available funds for purposes of any subsequent contract.

Section 223. Allocation of Funds.—Subsection (a) provides that no single public or non-profit private entity can receive Federal funding for more than eight fiscal years for provision of the same mental health services in the same mental health service area. Operations and staffing awards under the Community Mental Health Centers Act shall be considered funding for one fiscal year for purposes of this subsection. Federal funding may not exceed the following percentage of the cost of services to be provided: 90 percent in the first and second years, 80 percent in the third year, 70 percent in the fourth year, 60 percent in the fifth year, 50 percent in the sixth year, 40 percent in the seventh year, and 30 percent in the eighth year.

Subsection (b) provides that, notwithstanding the limitations in subsection (a) on the number of years of support and the maximum amount of funding, an entity that submits annual applications to provide services pursuant to section 208 may receive funding for such longer periods and for greater amounts as determined by the Secretary, except that no such funding may exceed $1.50 per capita of the population of the affected area.

Subsection (c) provides that any entity which receives eight years of funding under section 202 through 207 or 209 and which thereafter continues to provide substantially the same level of services for the same population for which it received funding under such section may receive funding to provide different services in the same mental health service area under any other section.

Subsection (d) provides that outpatient treatment and care and related support services for chronically mentally ill individuals shall account for no less than five percent of the Federal funding allotted within each State under this title in fiscal year 1982. This percentage would increase to no less than 10 percent for fiscal year 1983, 15 percent for fiscal year 1984 and 20 percent for fiscal year 1985. Further, funds for contracts to provide mental health services to chronically mentally ill individuals under section 202 shall account for no less than 10 percent and no more than 20 percent of all available funding under this title in fiscal years 1982 and 1983. In fiscal year 1984 the minimum and maximum percentages shall increase to 15 percent and 25 percent, respectively, and increase further in fiscal year 1985 to no less than 20 percent and no more than 30 percent. In addition, treatment and care for chronically mentally ill individuals must account for no less than 20 percent of the total funding allocated to community mental health centers under section 207 in all years.

Subsection (e) provides that no more than five percent of the funds allotted to community mental health centers under section 207 shall be allotted to entities which do not meet the governing board requirements of section 211(a)(1)(A).

Subsection (f) provides that no less than 90 percent of the Federal funds for contracts under this title shall be used to provide services at the local level.

Subsection (g) requires the Secretary to report annually to the Senate Committee on Labor and Human Resources and the House Committee on Interstate and Foreign Commerce regarding (1) the extent to which each community mental health center is serving chronically mentally ill individuals and (2) compliance with subsection (d)'s statewide and national requirements concerning the allocation of resources towards the service of chronically mentally ill individuals.

Section 224. Evaluation and Technical Assistance.—With the approval of the Secretary any entity may use a portion of its contract funds for evaluation of its project. The Secretary shall further set aside from appropriations for contracts under this title such sums as are determined to be appropriate for the evaluation of the extent to which entities have complied with applicable requirements and have advanced the objectives for which funding was provided. Not to exceed two percent of the funding available under this title for any fiscal year shall be available, as determined by the Secretary, to the Secretary to provide technical assistance and short-term training of personnel responsible for the implementation of contracts under this title.

Section 225. Conforming Amendments.—Amends Public Health Service Act provisions relating to functions of the Director of the National Institute of Mental Health, grants to Federal institutions, evaluation of programs, and functions of health systems agencies so as to make appropriate reference to the Mental Health Systems Act.

Subsection (e) amends the Community Mental Health Centers Act's listing of comprehensive services to require that followup services include the designation of a case manager responsible for the coordination of services for each resident discharged from a public inpatient psychiatric facility and for the development of an individual treat-

ment and services plan for such individual, pre-release consultation with respect to such individual, and preparation and submission of an annual report to the State Agency describing the manner in which the needs of chronically mentally ill individuals are being met. This requirement would apply to comprehensive community mental health centers funded under the Community Mental Health Centers Act as well as to recipients of funds under section 207 of this Act.

Section 226. Contracts for Indian Tribes.—Subsection (a) provides that an Indian tribe, as defined in the Indian Self-Determination Act, or an intertribal organization may submit an application directly to the Secretary to provide services eligible for funding under this title if such services will be available within, or would specifically serve, a federally recognized Indian reservation, any land area in Oklahoma that is held in trust by the United States for Indians or that is a restricted Indian-owned land area, a native village in Alaska (as defined in the Alaska Native Claims Settlement Act), or an Indian community the members of which are eligible for services under the Indian Health Care Improvement Act. Applications shall demonstrate the manner in which the proposed services will be consistent with the Tribal Specific Health Plan of the tribe or tribes to be served. A copy of the application shall be provided to the appropriate health system agency or agencies and to the appropriate State Agency for review and comment. The Secretary shall review, rank, select, and fund the application according to the same criteria used for other applications under this title. A tribe or intertribal organization receiving Federal funds under this title must, prior to receiving funds, enter into an annual performance contract with the Secretary pursuant to section 217 and shall receive payment directly from the Secretary, except as provided in subsection (b).

Subsection (b) provides that at the request of any Indian tribe or intertribal organization or any urban Indian organization (as defined in the Indian Health Care Improvement Act) the Secretary may enter into a contract with the Indian Health Service or any of its institutions, clinics, or other units for the purpose of providing services on the same terms and conditions as under subsection (a).

Subsection (c) provides that the fact that the area in which the members of an Indian tribe or organization reside is located in two or more mental health service areas of a State is no bar to funding under this section.

Section 227. Obligated Service for Mental Health Traineeship.—Amends section 303 of the Public Health Service Act, which authorizes mental health clinical training programs, by adding a new subsection (d) requiring that any individual who, after the date of enactment of the Mental Health Systems Act, has been informed in writing of the requirements and other provisions of this subsection and thereafter receives stipendiary support through an institutional or individual grant in psychology, psychiatry, nursing or social work that is not of a limited duration or experimental nature, as determined by the Secretary, is obligated to serve, in service determined by the Secretary to be appropriate, at the rate of one year for each year of the training support. Required service shall be in a public inpatient psychiatric facility, or for any entity eligible for a contract under title II of this

Act, or in a health manpower shortage area determined under title III of the Public Health Service Act, or in any other area or for any other entity designated by the Secretary. In developing criteria for determining institutions or entities for service payback, the Secretary shall give preference to those institutions, entities, or areas which in the Secretary's judgment have the greatest need for personnel to perform that service. Failure to pay back in service obligates the trainee to repay an amount equal to three times the cost of the grant award plus interest. Where the service has been paid back in part, the monetary payback is reduced proportionately. Where an individual also has an obligation to perform service because of receipt of a scholarship under the National Health Service Corps or an award under the National Research Service Awards program, the same service may not be used to meet more than one of these obligations. The obligation to perform services for the National Health Service Corps scholarship must be met before the obligation to perform service under the National Research Service Awards program or under this section. If any part of the obligation to perform service under the National Research Service Award program exists at the same time as any part of the obligation to perform service under this subsection, the Secretary will determine the manner and time of meeting those obligations.

TITLE III—MENTAL HEALTH RIGHTS AND ADVOCACY

Part A—Mental Health Rights

Section 301. Bill of Rights.—Subsection (a) sets forth a bill of rights for any person admitted to a program or facility for the purpose of receiving mental health services. These include: the right to appropriate treatment and related services under conditions supportive of such person's personal liberty and which restrict such liberty only to the extent necessary consistent with the person's treatment needs, applicable requirements of law, and applicable judicial orders; the right to an individualized written treatment or service plan, treatment based on such plan, periodic review and reassessment of treatment and service needs, and appropriate revision of such plan; the right to ongoing participation in the planning of treatment and services to be provided, and a reasonable explanation of the person's general mental condition, the objectives of treatment, possible adverse effects of recommended treatment, the reasons why a particular treatment is considered appropriate, the reason why access to certain visitors may not be appropriate, and any appropriate and available alternative treatments, services, and types of providers of mental health services; the right not to receive a mode or course of treatment in the absence of informed, voluntary, written consent, except during emergency situations or as permitted under applicable law pursuant to a judicial commitment order; the right not to participate in experimentation; the right to freedom from restraint or seclusion not provided as a mode or course of treatment, except during an emergency situation if documented by a written order; the right to a humane treatment environment that affords reasonable protection from harm; the right to confidentiality of records; the right to access, upon request, to the person's mental health care records, except that information provided

under an assurance of confidentiality may be refused, as may specific materials in such records deemed in writing by the health professional responsible for the person's mental health services to be detrimental to such person's health (with exceptions if another health professional selected by the patient determines that access is appropriate); the right, in the case of a person admitted on a residential or inpatient care basis, to converse with others privately, to have convenient and reasonable access to the telephone and the mails, and to see visitors except where such access is denied for treatment purposes and the denial has been recorded in writing; the right to be informed promptly at the time of admission and periodically thereafter of the rights under this part; the right to assert grievances and to a grievance procedure; the right of access to rights protection services and authorized advocates; the right to exercise these rights without reprisal, including reprisal in the form of denial of any appropriate available treatment; and the right to referral as appropriate to other providers of mental health services upon discharge.

Subsection (b) provides that these rights are in addition to any other statutory or constitutional rights otherwise afforded to all persons, to handicapped persons, or to recipients of health care services. It further provides that the rights to confidentiality of and access to records will remain applicable to a person after his or her discharge from the program or facility.

Subsection (c) provides that no otherwise eligible person shall be denied admission to a program or facility for mental health services as a reprisal for the exercise of these rights. It further provides that nothing in this part: obligates an individual mental health or health professional to administer treatment contrary to his or her clinical judgment; prevents any program or facility from discharging any person for whom the provision of appropriate treatment in the clinical judgment of the mental health professional primarily responsible for such person's treatment, is or has become impossible as a result of such person's refusal to consent to such treatment; requires a program or facility to admit any person who, while admitted on prior occasions to such program or facility, repeatedly frustrated the purposes of such admissions by withholding consent to proposed treatment; or obligates a program or facility to provide treatment to any person who is admitted solely for diagnostic or evaluative purposes. In addition, this subsection requires that an authorized advocate of a person admitted to a program or facility to receive mental health services shall have reasonable access to such person, the area where such person has received treatment, resided, or had access, and the records and information pertaining to such person's diagnosis, treatment, and related services to which the person has a right of access. With respect to those records to which the person has been denied access a procedure is established under which a court, after reviewing the records *in camera*, may reaffirm the denial, or order the records disclosed to the person, or order them disclosed only to the person's authorized advocate. Finally, this subsection requires each program or facility providing mental health services to post a notice listing and describing the rights under this title.

Subsection (d) provides that, where a person has been found incompetent by a court, the court-appointed guardian or representative may act on behalf of the person with respect to the exercise of the rights to consent to treatment and experimentation and the rights to confidentiality of and access to records. In the case of a minor who lacks capacity to exercise these rights under State law, a parent or legal guardian may exercise them. No one employed by or receiving remuneration from a program or facility may be appointed as the guardian or representative of a person admitted to the program or facility.

Section 302. Enforcement.—Subsection (a) provides that the Secretary of Health and Human Services shall prescribe regulations providing for compliance with enforcement of the rights provided in section 301, except that where programs and facilities fall within the jurisdiction of the Administrator of Veterans' Affairs or the Secretary of Defense, these individuals shall prescribe regulations providing for compliance and enforcement consistent with the laws governing the health programs carried out by their agency or Department, respectively.

Subsection (b) provides that the Secretary of Health and Human Services may withhold from any program or facility responsible for violation of a person's rights under section 301 further payments and Federal assistance under this Act, the Public Health Service Act, or the Community Mental Health Centers Act. Where programs fall within the jurisdiction of the Administrator of Veterans' Affairs or the Secretary of Defense, these officials are entitled to withhold Federal assistance under their respective authorities. Such withholding of support may last until the basis for such withholding no longer exists or corrective action has rectified the violation.

Subsection (c) provides that, in prescribing regulations under this section with respect to participation in experimentation, the Secretary of Health and Human Services, the Administrator of Veterans' Affairs, and the Secretary of Defense shall take into account the recommendations of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research.

Section 303. Right of Action.—Subsection (a) provides that if a person demonstrates to the court that he or she has exhausted the grievance procedure to which he or she is entitled under Section 301(a)(12), or that exhaustion of such procedure cannot afford timely relief, he or she may bring a civil action for the violation of any of his or her rights under this part in an appropriate United States district court, without regard to the amount in controversy.

Subsection (b) provides that the United States district courts shall have exclusive jurisdiction of any action brought under this section where the United States is a party. It further provides that if State or local jurisdiction exists for a cause of action under this part, such action may be brought in the appropriate State or local court, and the State or local court shall apply the requirements of subsection (a) with respect to such action.

Subsection (c) provides that in any action under this section the court may allow the prevailing party, other than the United States, a reasonable attorney's fee, as part of the costs, and that the United States and any State shall be liable for costs.

Subsection (d) makes clear that only persons to whom the rights of Section 301(a) apply are given a cause of action under this part.

Part B—Mental Health Advocacy Program

Section 304. Advocacy Program.—Subsection (a) provides that the Secretary shall establish a Mental Health Advocacy Program (MHAP) to make grants to and enter into contracts with public and nonprofit private entities to provide mental health advocacy services. The MHAP shall be located in the Office of the Secretary or in any other administrative unit of the Department of Health and Human Services that is independent of any administrative unit providing funding or reimbursement to providers of health, mental health, or related services. The Secretary shall assure that the MHAP has sufficient staff and adequate administrative and travel resources to carry out its program responsibilities.

Subsection (b) requires that, to be eligible to receive assistance under this part, an entity must demonstrate that: its personnel have the authority and capacity to pursue legal, administrative, and other appropriate remedies to assure and protect the rights of any person in connection with mental health services; except for the receipt of the Federal assistance under this part, it is an independent entity not directly associated with any agency that provides mental health services or funds for mental health services or is responsible for establishing or implementing mental health services policy; and it is a recipient of funds under the Legal Services Corporation Act or has agreed to coordinate its services with existing Legal Services Corporation projects, if any, in the area to be served.

Subsection (c) provides that no grant may be made or contract entered into under this section unless an application has been submitted to and approved by the Secretary and contains at least information and assurances relating to: the area to be served; consumer participation in the applicant's program design and policy determination processes; the range of legal and lay advocacy services to be provided; the training and qualifications of staff with respect to mental health care; knowledge of and appropriate cooperation with consumer, legal services, citizen, and other advocacy and rights protection programs within the area to be served and utilization, when appropriate, of available volunteers; and a procedure for establishing the goals and priorities of the program and assessing its performance.

Subsection (d) provides that payments under this section may be made in advance or by way of reimbursement. No grant or contract for an advocacy program serving an entire State shall be less than $50,000. Programs may receive additional financial support from other sources provided that they continue to be independent of mental health providers. Funds provided under this section shall supplement and not supplant other public funds. Not less than 10 percent and not more than 20 percent of funds available under this section shall be set aside for the provision of technical assistance, training, and backup support for advocacy projects receiving assistance under this part.

Subsection (e) provides that the Secretary shall establish a review group to review applications submitted under this part and to provide recommendations to the MHAP regarding training, technical assistance, and other support projects to be undertaken. Such group shall

include as members individuals with training and experience in providing mental health advocacy services and individuals representing citizen, consumer, and membership organizations that have demonstrated interest in mental health advocacy. No grant or contract shall be approved by the Secretary unless it has also been approved by the review group.

Subsection (f) requires that the Secretary assure that grants or contracts awarded under this section shall include provisions to assure that any use of funds for legal assitance will be subject to the same restrictions and regulations prescribed under the Legal Services Corporation Act.

Section 305. Report on Advocacy.—Subsection (a) requires that the Comptroller General conduct a study to examine the performance of advocacy programs that represent: persons admitted to programs or facilities to receive mental health services; persons who are developmentally disabled or severely disabled; and youth, racial and ethnic minorities, women and other appropriate groups, with respect to the constitutional and statutory rights of these persons.

Subsection (b) requires that this report be submitted to the President and the Congress not later than 18 months after the effective date of this title and shall include legislative recommendations if appropriate.

Subsection (c) requires that the report assess the performance of advocacy program established by Congress or undertaken as demonstration projects within executive agencies designed to protect the constitutional and statutory rights of priority population groups. The report shall, at a minimum: summarize the advocacy activities and evaluate the performance of the MHAP and advocacy efforts authorized by the Development Disabilities Assistance and Bill of Rights Act and the Rehabilitation Act; describe and assess the role of the Legal Services Corporation in providing legal services to such priority population groups; describe and assess the role of the various volunteer agencies and other institutions and professions in providing advocacy services; assess the need for advocacy services currently not being provided; make recommendations regarding the efficient provision of advocacy services; make recommendations regarding measures to improve the Federal advocacy effort on behalf of youth, racial and ethnic minorities, and women; and assess the impact of advocacy programs upon the cost and quality of care and treatment in programs and facilities.

Part C—Miscellaneous

Section 306. Definitions.—Provides definitions of the following terms used in this title: "admitted"; "emergency situation"; "mental health services"; "program or facility"; "responsible mental health and professional"; "qualified advocate"; "authorized advocate"; and "treatment."

Section 307. Advocate Registration.—Provides that the Governor of each State shall (1) establish a procedure under which citizen or consumer organizations that have demonstrated an interest in mental health advocacy and intend to provide the services of individuals qualified to act as qualified advocates in a State for purposes of this title may apply for the registration of such individuals as qualified ad-

vocates, (2) review the qualifiactions of such organizations and determine if such organizations are capable of providing services by individuals qualified to serve as advocates in a responsible manner, and (3) if affirmative determinations are made, provide for the registration of the organizations in question and the individuals designated by them to serve as qualified advocates.

Section 313. Effective Date.—Provides that—except for section 302 (a) relating to the development of regulations and section 304(e)(1) relating to the formation of a review group for MHAP—the provisions of this title shall become effective on the date one year after the date of enactment of this Act.

TITLE IV—ASSOCIATE DIRECTOR FOR MINORITY CONCERNS

Section 401. Associate Director for Minority Concerns.—Amends the statutory establishment of the National Institute of Mental Health to provide that its Director shall designate an Associate Director for Minority Concerns to develop and coordinate prevention, treatment, research and administrative policies and programs to ensure increased focus on minority populations. The Associate Director will assist the Director in assuring that the Institute: supports programs with regard to the delivery of mental health services to minority populations, including demonstration projects; develops a plan to increase the representation of minorities in mental health service delivery and manpower programs; supports basic and applied research on minority mental health; studies the effect of racial, age, and sexual discrimination on institutions and individuals; develops systems to assist minorities in adapting to, and coping with, the effects of discrimination; supports and develops research, demonstration, and training programs aimed at eliminating institutional discrimination; and provides for increased emphasis on the concerns of minority populations in training programs, service delivery programs, and research endeavors. The Secretary shall report to Congress every three years on the Institute's activities in carrying out the provisions of this section. The Associate Director shall not be deemed to have exclusive jurisdiction of the Institute's responsibility to develop effective policies and programs for minority populations.

TITLE V—PREVENTION

Section 501. Prevention Unit.—Amends the statutory establishment of the National Institute of Mental Health to provide that its Director shall designate an administrative unit for the prevention of mental illness and the promotion of mental health. This unit shall design national goals and establish national priorities related to the prevention of mental illness and to the promotion of mental health and encourage and assist local entities and State agencies to achieve the goals and priorities. The Director shall designate an individual to develop and coordinate prevention policies and programs and to assure increased focus on the prevention of mental illness and the promotion of mental health. That individual would assist the Director in assuring that the Institute: enhances, focuses, and coordinates the research and training activities being carried out under existing legislative authori-

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ties which are aimed at preventing mental illness and promoting mental health; encourages and assists efforts to prevent mental illness, particularly efforts relating to children and adolescents; and emphasizes and strengthens planning, implementation and evaluation of these activities. The Secretary shall report to the Congress every three years on the Institute's activities in carrying out these provisions.

TITLE VI—MISCELLANEOUS

Section 601. Community Mental Health Centers Act Appropriations.—Provides for a one year reauthorization, for fiscal year 1981, of existing authorities in the Community Mental Health Centers Act. The following sums would be authorized: $1 million for planning grants, $42 million for operation grants, $19 million for consultation and education services, and $25 million for financial distress grants. Further provides that no funds may be appropriated under the Community Mental Health Centers Act for any period after fiscal year 1982.

Section 602. Authorization of Appropriations.—Subsection (a) authorizes to be appropriated for funding under title II $400 million for fiscal year 1982, $450 million for fiscal year 1983, $500 million for fiscal year 1984, and $550 million for fiscal year 1985.

Subsection (b) repeals section 237 of the Community Mental Health Centers Act and section 314(g) of the Public Health Service Act, pertaining to State mental health plans, and in lieu thereof authorizes to be appropriated to assist States in carrying out their responsibilities under this Act for planning and program design, data collection, data analysis, research, evaluation, setting and enforcing regulatory and other standards, reporting to the Secretary, and establishing, expanding, or operating internal rights protection programs, $20 million for fiscal year 1982 and such sums as may be necessary for each of the next three fiscal years. States must comply with the provisions of section 307, relating to the registration of advocates, to be eligible to receive funds under this subsection.

Subsection (c) authorizes to be appropriated for funding under Title III $10 million for fiscal year 1982 and such sums as may be necessary for each of the next three fiscal years.

Section 603. Report on Shelter and Basic Living Needs of Chronically Mentally Ill Individuals.—Subsection (a) provides that the Secretaries of Health and Human Services and Housing and Urban Development shall jointly submit to the Senate Committees on Labor and Human Resources and Banking, Housing, and Urban Affairs and the House Committees on Interstate and Foreign Commerce and Banking, Finance, and Urban Affairs a report relating to Federal efforts to respond to the shelter and basic living needs of chronically mentally ill individuals.

Subsection (b) provides that this report shall include: an analysis of the extent to which chronically mentally ill individuals remain inappropriately housed in institutional facilities or have otherwise inadequate or inappropriate housing arrangements; an analysis of available permanent noninstitutional housing arrangements for chronically mentally ill persons; an evaluation of ongoing permanent and demonstration programs designed to provide noninstitutional shelter

and basic living services for the chronically mentally ill; recommendations of measures to encourage States to coordinate and link the provisions in State health plans which relate to mental health and in particular the shelter and basic living needs of chronically mentally ill individuals with local and State housing plans; and recommendations for Federal legislation relating to the provision of permanent residential noninstitutional housing arrangements and basic living services for chronically mentally ill individuals and for Federal initiatives which would lead to improved shelter and basic living services.

Subsection (c) provides that the report is to be submitted no later than January 1, 1981.

Section 604. Report on the Implementation of the Mental Health Systems Act.—Provides that the Secretary shall submit a report to the Senate Committee on Labor and Human Resources and the House Committee on Interstate and Foreign Commerce regarding the implementation of the Mental Health Systems Act. This report would include: a description of the number and types of proposals which have been funded, the populations served, and the kinds of services provided; an analysis of the extent to which the purposes of the Act have and are being achieved; an analysis of the major problems which have arisen in implementing the Act; and recommendations regarding possible changes in the basic policy, design, requirements, criteria, and technical features of the Act which would improve the provision of care and further the prevention of mental illness.

Subsection (c) provides that this report shall be submitted no later than January 1, 1985.

Section 605. Confidentiality of Mental Health Record.—Amends the Public Health Service Act by adding a new section 515, "Confidentiality of Mental Health Records", to the Public Health Service Act.

Subsection (a) of the new section 515 provides that mental health records maintained in connection with the performance of any program or activity relating to mental health or health education, training, treatment, services, rehabilitation, or research which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall be kept confidential and be disclosed only for the purposes expressly authorized by this section.

Subsection (b) of section 515 provides for release of information with patient consent, but only to the extent permitted under regulations prescribed pursuant to subsection (h). Subsection (b) also permits disclosure of information without patient consent in medical emergencies; for scientific research, management or financial audits, or program evaluation; and if authorized by an appropriate court order, In the case of inpatients, information pertaining to the patient's location and general physical condition could also be divulged in certain circumstances. Non-consensual disclosures are also permitted where the individual responsible for the patient's diagnostic or treatment services reasonably considers disclosure necessary to protect against a clear and substantial risk of imminent serious bodily harm to the patient or others. A Federal department or agency that has provided care and treatment services to the patient may also disclose records as necessary for the purpose of obtaining third party payment.

Subsection (c) provides that, except as authorized by a court order granted under subsection (b), no record referred to in subsection (a)

may be used to initiate or substantiate any criminal charges against a patient or to conduct any investigation of a patient.

Subsection (d) provides that the prohibitions of this section shall continue to apply to records concerning any individual who has been a patient, irrespective of whether or when he or she ceases to be a patient. Further, for purposes of section 303 of the Public Health Service Act (pertaining to protection of the privacy of research subjects), persons who maintain records referred to in subsection (a) of that section are deemed to be authorized by the Secretary to protect the privacy of individuals.

Subsection (e) provides that the prohibitions of this section do not apply to the interchange of records within or between the Armed Forces or the Veterans' Administration for certain purposes.

Subsection (f) requires that any person who obtains a patient's consent to disclosure of a record shall assure that such consent is informed and voluntary.

Subsection (g) provides that any person who violates any provision of this section or any regulation issued pursuant to it shall be fined not more than $500 for a first offense and not more than $5,000 for each subsequent offense.

Subsection (h) directs the Secretary to prescribe regulations to carry out the purposes of this section. The regulation may contain such definitions and provide for safeguards and procedures, including procedures and criteria for the issuance and scope of court orders for nonconsensual release, as in the judgment of the Secretary are necessary or proper to effectuate the purposes of this section and to facilitate compliance.

Subsection (i) directs the Administrator of Veterans' Affairs, to the maximum feasible extent consistent with his or her responsibilities, to prescribe regulations making applicable the regulations prescribed by the Secretary to records maintained by the Veterans' Administration for its grantees in connection with the provision of hospital care, nursing home care, domiciliary care, and medical services. In prescribing and implementing regulations the Administrator shall from time to time consult with the Secretary to achieve the maximum possible coordination and implementation of both sets of regulations.

Subsection (j) defines the terms "identity", "record", and "patient".

TITLE VII—RAPE PREVENTION AND CONTROL

Section 701. Rape Prevention and Control.—Subsection (a) amends the Community Mental Health Centers Act by adding a new section 232, "Rape Services Development and Demonstration Projects".

Subsection (a) of that new section provides that the Secretary, acting through the National Center for the Prevention and Control of Rape, shall make grants to and enter into contracts with public and private entities to develop or demonstrate new and innovative methods to provide rape services.

Subsection (b) of that new section provides that awards may be made for demonstration or development projects for any one or more of the following: training programs; treatment programs providing: counseling for the victim, the victim's family, or the offender; infor-

mation about or referral to medical, mental health, social, or legal services; consultation with allied professionals; or follow-up counseling with the victim, the victim's immediate family, or the offender; community education; offender rehabilitation and counseling; self-help programs for victims, as well as potential victims; telephone systems to provide assistance to the victim; emergency shelter programs; or projects likely to result in the development and demonstration of methods of preventing rape, or which address social problems related to rape.

Subsection (c) provides that applications for assistance must be submitted to and approved by the Secretary, who will determine the amount of any grant or contract and the time and manner of payment.

Subsection (d) requires each entity participating in a program under this section to establish a recordkeeping system to insure the protection of the privacy of the victim, as well as of other individuals involved, and establish internal procedures to measure progress in achieving the goals stated by the grantee or contractor in its application.

Subsection (e) directs the Secretary to develop standards and outcome criteria to measure the effectiveness of the program. They will be developed in consultation with the National Rape Prevention and Control Advisory Committee and established within 90 days after the date of enactment of this section.

Subsection (f) provides that, except as required by Federal law, no Federal Government officer or employee or any recipient of assistance shall use or reveal any information furnished by or on behalf of a victim and identifiable to any specific person for any purpose other than that for which it was obtained. Such information shall be immune from legal process and not be admitted in evidence or used for any purpose in any action, suit, or other judicial, legislative, or administrative proceeding.

Subsection (g) provides that the annual submission of a report to Congress on activities of the National Center for the Prevention and Control of Rape shall be submitted not later than March 1 of each year and include, in addition to the existing report requirements of section 231 of the Community Mental Health Centers Act, a summary of the activities funded pursuant to this section and a review of their effectiveness.

Subsection (h) provides that not more than 5 percent of any funds appropriated to carry out the provisions of this section for any fiscal year may be used by the Secretary to provide technical assistance to any public or private entity which desires to submit an application under this section. The Secretary may provide such assistance upon request if he or she determines that the entity does not possess the resources or expertise necessary otherwise to develop and submit an application.

Subsection (i) requires the Secretary, to the extent feasible, to coordinate development and demonstration projects carried out under this section with other activities relating to rape carried out by the Secretary and the heads of other Federal agencies.

Subsection (j) requires that not more than 90 percent of the cost of any project shall be funded by a grant or contract under this section.

Subsection (k) authorizes to be appropriated $6 million for fiscal year 1981, $9 million for fiscal year 1982, and $12 million for fiscal year 1983.

Finally, subsection (e) of the new section provides that the Secretary, in carrying out his or her functions in administering the provisions of this section, is authorized to obtain the services of not more than ten full time staff members to assist in carrying out the functions of the National Center for the Prevention and Control of Rape, and authorizes to be appropriated for this purpose $200,000 for fiscal year 1981, $212,000 for fiscal year 1982, and $224,000 for fiscal year 1983.

Subsection (b) of sec. 701 extends the authorization of appropriations for existing rape-related programs contained in section 231(d) of the Community Mental Health Centers Act. Authorized appropriations of $10,200,000 for fiscal year 1981, $11,500,000 for fiscal year 1982, and $13,000,000 for fiscal year 1983 are provided.

Subsection (c) provides that sections 231 and 232 of the Community Mental Health Centers Act shall be moved and redesignated as sections 456 and 457 of the Public Health Service Act.

IX. Changes in Existing Law

In compliance with subsection (4) of rule XXIX of the Standing Rules of the Senate, changes in existing law made by the bill as reported are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman) :

PUBLIC HEALTH SERVICE ACT

TITLE I—SHORT TITLE AND DEFINITIONS

SHORT TITLE

Section 1. This Act may be cited as the "Public Health Service Act".

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TITLE III—GENERAL POWERS AND DUTIES OF PUBLIC HEALTH SERVICE

Part A—Research and Investigation

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MENTAL HEALTH

Sec. 303. (a) * * *

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(d) (1) Any individual who, after the date of enactment of the Mental Health Systems Act, has been informed in writing of the requirements and other provisions of this subsection and thereafter accepts a clinical traineeship in psychology, psychiatry, nursing, or social work, under subsection (a) (1) that is not of a limited duration or experimental nature (as determined by the Secretary) is obligated to serve, in service determined by the Secretary to be appropriate in the light of the individual's training and experience, at the rate of one year for each year (or academic year, whichever the Secretary determines to be appropriate) of the traineeship.

(2) The service required under paragraph (1) shall be in a public inpatient psychiatric facility institution, or for any entity eligible for a contract under title II of the Mental Health Systems Act, or in a health manpower shortage area (as determined under subpart II of part D of title III of the Public Health Service Act), or in any other area or for any other entity designated by the Secretary, and shall begin within such period after the termination of the traineeship as the Secretary may determine. In developing criteria for determining for which insti-

tutions or entities or in which areas, referred to in the preceding sentence, individuals must perform service under this paragraph, the Secretary shall give preference to institutions, entities, or areas which in the Secretary's judgment have the greatest need for personnel to perform that service unless, for good cause shown to the Secretary, the individual requests performance of other service under this paragraph.

(3) Any individual who fails to perform the service required of the individual under this subsection within the period prescribed by the Secretary is obligated to repay to the United States an amount equal to three times the cost of the traineeship (including stipends and allowances) plus interest at the maximum legal rate at the time of payment of the traineeship, multiplied, in any case in which the service so required has been performed in part, by the percentage which the length of the service so performed is of the length of the service so required to be performed.

(4)(A) In the case of any individual any part of whose obligation to perform service under this subsection exists at the same time as any part of the individual's obligation to perform service under section 752 or 753 (because of receipt of a scholarship under subpart IV of part C of title VII) or the individual's obligation to perform service under section 472 (because of receipt of a National Research Service Award thereunder), or both, the same service may not be used to any extent to meet more than one of those obligations.

(B) In any case to which subparagraph (A) is applicable and in which one of the obligations is to perform service under section 752 or 753, the obligation to perform service under that section must me met (by performance of the required service or payment of damages) before the obligation to perform service under this subsection or under section 472.

(C) In any case to which subparagraph (A) is applicable, if any part of the obligation to perform service under section 472 exists at the same time as any part of the obligation to perform service under this subsection, the manner and time of meeting each obligation shall be prescribed by the Secretary.

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GRANTS FOR COMPREHENSIVE HEALTH PLANNING AND PUBLIC HEALTH SERVICES

SEC. 314. (a) * * *

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[STATE MENTAL HEALTH PROGRAMS]

[(g)(1) From allotments made pursuant to paragraph (4), the Secretary shall make grants to State mental health authorities to assist them in meeting the cost of carrying out their functions under title XV of this Act and under section 237 of the Community Mental Health Centers Act and, after September 30, 1979, in meeting the costs of providing mental health services.

[(2) No grant may be made under paragraph (1) unless an application therefor has been submitted to and approved by the Secretary. Such an application shall be submitted in such form and manner and shall contain such information as the Secretary may require, and shall contain or be supported by assurances satisfactory to the Secretary that—

[(A) the mental health services provided within the State under the grant applied for will be provided in accordance with the State health plan in effect for such State under section 1524(c);

[(B) funds received under the grant applied for will (i) be used to supplement and, to the extent practical, to increase the level of non-Federal funds that would otherwise be made available for the purposes for which the grant funds are provided, and (ii) not be used to supplant such non-Federal funds;

[(C) the State mental health authority will—

[(i) provide for such fiscal control and fund accounting procedures as may be necessary to assure the proper disbursements of and accounting for funds received under grants under paragraph (1);

[(ii) from time to time, but not less often than annually, report to the Secretary (through a uniform national reporting system and by such categories as the Secretary may prescribe) a description of the mental health services provided in the State in the fiscal year for which the grant applied for is made and the amount of funds obligated in such fiscal year for the provision of each such category of services; and

[(iii) make such reports (in such form and containing such information as the Secretary may prescribe) as the Secretary may reasonably require, and keep such records and afford such access thereto as the Secretary may find necessary to assure the correctness of, and to verify, such reports;

[(D) the State mental health authority will—

[(i) perform the duties prescribed by section 237 of the Community Mental Health Centers Act;

[(ii) prescribe and provide for the enforcement of minimum standards for the maintenance and operation of mental health programs and facilities (including community mental health centers) within the State;

[(iii) provide for assistance to courts and other public agencies and to appropriate private agencies to facilitate (I) screening by community mental health centers (or, if there are no such centers, other appropriate entities) of residents of the State who are being considered for inpatient care in a mental health facility to determine if such care is necessary, and (II) provision of followup care by community mental health centers (or, if there are no such centers, by other appropriate entities) for residents of the State who have been discharged from mental health facilities; and

[(iv) establish and carry out a plan which is consistent with the State health plan in effect for the State under section 1524(c) and—

[(I) is designed to eliminate inappropriate placement in institutions of persons with mental health problems,

to insure the availability of appropriate noninstitutional services for such persons, and to improve the quality of care for those with mental health problems for whom institutional care is appropriate, and

[(II) shall include fair and equitable arrangements (as determined by the Secretary after consultation with the Secretary of Labor) to protect the interests of employees affected by actions described in subclause (I), including arrangements designed to preserve employee rights and benefits and to provide training and retraining of such employees where necessary and arrangements under which maximum effort will be made to guarantee the employment of such employees.

[(3)(A) The Secretary shall review annually the activities undertaken by each State mental health authority with an approved application to determine if it complied with the assurances provided with the application. The Secretary may not approve an application submitted under paragraph (2) if the Secretary determines—

[(i) the State for which the application was submitted did not comply with assurances provided with a prior application under paragraph (2), and

[(ii) he cannot be assured that the State will comply with the assurances provided with the application under consideration.

[(B) Whenever the Secretary, after reasonable notice and opportunity for a hearing to the State mental health authority of a State, finds that, with respect to funds paid to the authority under a grant under paragraph (1), there is a failure to comply substantially with assurances provided under paragraph (2) with respect to the receipt of such grant, the Secretary shall notify the authority that further payments will not be made to it under such grant (or, in his discretion, that further payments will not be made to it from such grant for activities in which there is such failure), until he is satisfied that there will no longer be such failure. Until he is so satisfied, the Secretary shall make no payment to such authority from such grant, or shall limit payment under such grant to activities in which there is no such failure.

[(4) For the purpose of determining the total amount of grants that may be made to the State mental health authorities of each State, the Secretary shall, in each fiscal year and in accordance with regulations, allot the sums appropriated for such year under paragraph (7) among the States on the basis of the population and the financial need of the respective States. The populations of the States shall be determined on the basis of the latest figures for the population of the States available from the Department of Commerce.

[(5)(A) The Secretary shall determine the amount of any grant under paragraph (1); but the amount of grants made in any fiscal year to the mental health authorities of any State may not exceed the amount of the State's allotment available for obligation in such fiscal year. Payments under such grants may be made in advance or by way of reimbursement, and at such intervals and on such conditions, as the Secretary finds necessary.

[(B) The Secretary, at the request of a State mental health authority, may reduce the amount of the grant to the authority under paragraph (1) by—

[(i) the fair market value of any supplies or equipment furnished the State mental health authority, and

[(ii) the amount of the pay, allowances, and travel expenses of any officer or employee of the Government when detailed to the State mental health authority and the amount of any other costs incurred in connection with the detail of such officer or employee,

when the furnishing of such supplies or equipment or the detail of such an officer or employee is for the convenience of and at the request of the State mental health authority and for the purpose of carrying out any project with respect to which its grant under paragraph (1) is made. The amount by which any such grant is so reduced shall be available for payment by the Secretary of the costs incurred in furnishing the supplies or equipment, or in detailing the personnel, on which the reduction of such grant is based, and such amount shall be deemed as part of the grant and shall be deemed to have been paid to the State mental health authority.

[(6) In any fiscal year not less than 70 per centum of the amount of a State's grant shall be available only for the provision of mental health services and for the conduct of mental health planning activities in communities of the State.

[(7) For the purpose of making grants under this subsection there are authorized to be appropriated $5,000,000 for the fiscal year ending September 30, 1979, $20,000,000 for the fiscal year ending September 30, 1980, and $25,000,000 for the fiscal year ending September 30, 1981.

[(8) Regulations (including substantive amendments to regulations) under this subsection shall be promulgated by the Secretary after consultation with a conference of State mental health authorities. The Secretary shall consult with such conference before the publication of proposals for such regulations or amendments.]

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TITLE IV—NATIONAL RESEARCH INSTITUTES

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Part G—National Institute of Mental Health

ESTABLISHMENT OF INSTITUTE

Sec. 455. (a) There is established the National Institute of Mental Health (hereinafter in this part referred to as the "Institute") to administer the programs and authorities of the Secretary with respect to mental health. The Secretary, acting through the Institute, shall, in carrying out the purposes of sections 301 and 303 of this Act [and], the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (other than part C of title II), *and the Mental Health Systems Act* with respect to mental illness, develop

and conduct comprehensive health, education, training, research, and planning programs for the prevention and treatment of mental illness and for the rehabilitation of the mentally ill. The Secretary shall carry out through the Institute the administrative and financial management, policy development and planning, evaluation, and public information functions which are required for the implementation of such programs and authorities.

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(d)(1) The Director shall designate an Associate Director for Minority Concerns to develop and coordinate prevention, treatment, research, and administrative policies and programs to assure increased focus on minority populations.

(2) The Associate Director for Minority Concerns shall assist the Director in assuring that the Institute—

(A) supports programs with regard to the delivery of mental health services to minority populations, including demonstration projects;

(B) develops a plan to increase the representation of minority populations in mental health service delivery and manpower programs with an emphasis on developing bilingual and bicultural programs;

(C) supports programs of basic and applied social and behavioral research on minority mental health;

(D) studies the effects of racial, age, and sexual discrimination on institutions and individuals, including majority institutions and individuals;

(E) develops systems to assist minority populations in adapting to, and coping with, the effects of racial, age, and sexual discrimination;

(F) supports and develops research, demonstration, and training programs aimed at eliminating institutional racial, age, and sexual discrimination; and

(G) provides for increased emphasis on the concerns of minority populations in training programs, service delivery programs, and research endeavors.

(3) The Secretary shall report to Congress every 3 years on the Institute's activities in carrying out the provisions of this subsection.

(4) Nothing contained in this subsection shall be construed to prevent or impair the administration or enforcement of any other provision of Federal law, nor shall the Associate Director for Minority Concerns be deemed to have exclusive jurisdiction of the Institute's responsibility to develop effective policies and programs for minority populations.

(e)(1) The Director shall designate an administrative unit for prevention of mental illness and the promotion of mental health. The purpose of such unit shall be to—

(A) design national goals and establish national priorities related to the prevention of mental illness;

(B) design national goals and establish national priorities related to the promotion of mental health; and

(C) encourage and assist local entities and State agencies to achieve the goals and priorities described in this paragraph.

(2) The Director shall designate an individual to develop and coordinate prevention policies and programs and to assure increased focus on the prevention of mental illness and the promotion of mental health. This individual shall assist the Director in assuring that the Institute—

(A) enhances, focuses, and coordinates the research and training activities being carried out under existing legislative authorities which are aimed at preventing mental illness and promoting mental health;

(B) encourages and assists local, State, and Federal efforts to prevent mental illness and promote mental health, particularly efforts relating to children and adolescents; and

(C) emphasizes and strengthens orderly planning, implementation, and evaluation of the activities described in this paragraph.

(3) The Secretary shall report to the Congress every three years on the Institute's activities in carrying out the provisions of this subsection.

RAPE PREVENTION AND CONTROL [1]

SEC. 456. (a) The Secretary shall establish within the National Institute of Mental Health an identifiable administrative unit to be known as the National Center for the Prevention and Control of Rape (hereinafter in this section referred to as the "Center").

(b) (1) The Secretary, acting through the Center, may, directly or by grant, carry out the following:

(A) A continuing study of rape, including a study and investigation of—

(i) the effectiveness of existing Federal, State, and local laws dealing with rape;

(ii) the relationship, if any, between traditional legal and social attitudes toward sexual roles, the act of rape, and the formulation of laws dealing with rape;

(iii) the treatment of the victims of rape by law enforcement agencies, hospitals or other medical institutions, prosecutors, and the courts;

(iv) the causes of rape, identifying to the degree possible—

(I) social conditions which encourage sexual attacks, and

(II) the motives of offenders, and

(v) the impact of rape on the victim and family of the victim;

(vi) sexual assaults in correctional institutions;

(vii) the actual incidence of forcible rape as compared to the reported incidence of forcible rape and the reasons for any difference in such incidences; and

(viii) the effectiveness of existing private and local and State government educational, counseling, and other programs designed to prevent and control rape.

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[1] This section was previously Section 231 of the Community Mental Health Centers Act.

(B) The compilation, analysis, and publication of summaries of the continuing study conducted under subparagraph (A) and the research and demonstration projects conducted under subparagraph (E). The Secretary shall annually submit to the Congress a summary of such study and projects together with recommendations where appropriate.

(C) The development and maintenance of an information clearinghouse with regard to—

(i) the prevention and control of rape;

(ii) the treatment and counseling of the victims of rape and their families; and

(iii) the rehabilitation of offenders.

(D) The compliation and publication of training materials for personnel who are engaged or intend to engage in programs designed to prevent and control rape.

(E) Assistance to community mental health centers and other qualified public and nonprofit private entities in conducting research and demonstration projects concerning the prevention and control of rape, including projects (i) for the planning, developing, implementing, and evaluating of alternative methods used in the prevention and control of rape, the treatment and counseling of the victims of rape and their families, and the rehabilitation of offenders; (ii) for the application of such alternative methods; and (iii) for the promotion of community awareness of the specific locations in which, and the specific social and other conditions under which, sexual attacks are most likely to occur.

(F) Assistance to community mental health centers in meeting the costs of providing consultation and education services respecting rape.

(2) For purposes of this subsection, the term "rape" includes statutory and attempted rape and any other criminal sexual assault (whether homosexual or heterosexual) which involves force or the threat of force.

(c) The Secretary shall appoint an advisory committee to advise, consult with, and make recommendations to him on the implementation of subsection (b). The recommendations of the committee shall be submitted directly to the Secretary without review or revision by any person without the consent of the committee. The Secretary shall appoint to such committee persons who are particularly qualified to assist in carrying out the functions of the committee. A majority of the members of the committee shall be women. Members of the advisory committee shall receive compensation at rates, not to exceed the daily equivalent of the annual rate in effect for grade GS–18 of the general schedule, for each day (including travel-time) they are engaged in the performance of their duties as members of the advisory committee and, while so serving away from their homes or regular places of business, each member shall be allowed travel expenses, including per diem in lieu of subsistence, in the same manner as authorized by section 5703 of title 5, United States Code, for persons in Government service employed intermittently.

(d) For the purpose of carrying out subsection (b), there are authorized to be appropriated $7,000,000 for fiscal year 1976, $10,000,000

for the fiscal year ending September 30, 1977, $7,880,000 for the fiscal year ending September 30, 1978, $8,000,000 for the fiscal year ending September 30, 1979, [and] $9,000,000 for the fiscal year ending September 30, 1980[.] , *$10,200,000 for the fiscal year ending September 30, 1981, $11,5000,000 for the fiscal year ending September 30, 1982, and $13,000,000 for the fiscal year ending September 30, 1983.*

RAPE SERVICES DEVELOPMENT AND DEMONSTRATION PROJECTS [2]

SEC. 457. (a) The Secretary, acting through the National Center for the Protection and Control of Rape, shall make grants to, and enter into contracts with, public and private entities to develop or demonstrate new and innovative methods to provide rape services.

(b) The Secretary may award grants and contracts under subsection (a) for development or demonstration projects for any one or more of the following—

(1) training programs (including counseling techniques for the victim or the offender) for professional, paraprofessional, and volunteer personnel in the fields of law, social service, mental health, and other related fields in which personnel are or will become engaged in areas relating to the problems of rape;

(2) treatment programs providing—

(A) counseling for the victim, the victim's immediate family, or the offender;

(B) information about or referral to medical, mental health, social, or legal services including necessary transportation costs and accompaniment to such services;

(C) consultation with allied professionals; or

(D) followup counseling for the victim, the victim's immediate family, or the offender;

(3) community education;

(4) offender rehabilitation and counseling;

(5) self-help programs for victims, as well as potential victims;

(6) telephone systems to provide assistance to the victim;

(7) emergency shelter programs; or

(8) projects which are likely to result in the development and demonstration of methods of preventing rape, or which address social problems related to rape.

(c) (1) No grant may be made or contract entered into under this section unless an application therefor is submitted to, and approved by, the Secretary. Such an application shall be submitted in such form and manner and shall contain such information as the Secretary shall prescribe.

(2) The amount of any grant or contract under this section shall be determined by the Secretary.

(3) The Secretary may make payments under this section in advance or by way of reimbursement, and at such intervals and on such conditions as the Secretary may find necessary.

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[2] This section was initially designated as Section 232 of the Community Mental Health Centers Act.

(d) Each entity participating in a program under this section shall—

(1) establish a recordkeeping system to insure the protection of the privacy of the victim, as well as of other individuals involved in accordance with subsection (f); and

(2) establish internal procedures to measure progress in achieving the goals stated by the grantee or contractor in its application.

(e) The Secretary shall develop standards and outcome criteria by which the effectiveness of this program shall be measured. Such standards and criteria shall be developed in consultation with the National Rape Prevention and Control Advisory Committee and established within ninety days after the date of the enactment of this section. The Secretary shall review the effectiveness of the development and demonstration projects carried out pursuant to this section.

(f) Except as provided by Federal law other than this section, no officer or employee of the Federal Government, nor any recipient of assistance under the provisions of this section shall use or reveal any information furnished by or on behalf of a victim and identifiable to any specific private person for any purpose other than the purpose for which it was obtained in accordance with this section. Such information and copies thereof, when supplied to, or gathered by, such officer or employee of the Federal Government, or any recipient of assistance under the provisions of this section, shall be immune from legal process, and shall not, without the consent of the person furnishing such information, be admitted as evidence or used for any purpose in any action, suit, or other judicial, legislative, or administrative proceedings.

(g) The annual submission to Congress under section 456(b)(1)(B) shall be submitted not later than March 1 of each year and shall include, in addition to the requirements of section 456—

(1) a summary of the activities funded pursuant to this section; and

(2) a review of the effectiveness of the activities carried out pursuant to this section.

(h) Not more than 5 percent of any funds appropriated to carry out the provisions of this section for any fiscal year may be used by the Secretary to provide technical assistance to any public or private entity which desires to submit an application under this section. The Secretary may provide such assistance, upon request, if the Secretary determines that the entity does not possess the resources or expertise necessary to develop and submit an application without such assistance.

(i) The Secretary shall, to the extent feasible, coordinate development and demonstration projects carried out under this section with other activities relating to rape carried out by the Secretary and the heads of other Federal agencies.

(j) Not more than 90 percent of the costs of any project shall be funded by a grant or contract under this section.

(k) There are authorized to be appropriated to carry out the provisions of this section $6,000,000 for the fiscal year ending September 30, 1981, $9,000,000 for the fiscal year ending September 30, 1982, and $12,000,000 for the fiscal year ending September 30, 1983.

(l) The Secretary, notwithstanding the provisions of section 311 of the Civil Service Act of 1978 (Public Law 95–454, 92 Stat. 1111), in carrying out his functions and administering the provisions of this section and without regard to any other provision of this Act, is authorized to obtain the services of not more than ten full-time staff members to assist in carrying out the functions of the National Center for the Prevention and Control of Rape. There are authorized to be appropriated to carry out the provisions of this subsection $200,000 for the fiscal year ending September 30, 1981, $212,000 for the fiscal year ending September 30, 1982, and $224,000 for the fiscal year ending September 30, 1983.

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TITLE V—MISCELLANEOUS

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GRANTS TO FEDERAL INSTITUTIONS

SEC. 507. Appropriations to the Public Health Service available under this Act for research, training, or demonstration project grants or for grants to expand existing treatment and research programs and facilities for alcoholism, narcotic addiction, drug abuse, and drug dependence, [and] appropriations available under the Community Mental Health Centers Act for construction and staffing of community mental health centers and alcoholism and narcotic addiction, drug abuse, and drug dependence facilities, *and appropriations under title VI of the Mental Health Systems Act* shall also be available, on the same terms and conditions as apply to non-Federal institutions, for grants for the same purpose to Federal institutions, except that grants to such Federal institutions may be funded at 100 per centum of the costs.

* * * * * * *

EVALUATION OF PROGRAMS

SEC. 513. Such portion as the Secretary may determine, but not more than 1 per centum, of any appropriation for grants, contracts, or other payments under any provision of this Act, the Mental Retardation Facilities Construction Act, the Community Mental Health Centers Act, *the Mental Health Systems Act*, the Act of August 5, 1954 (Public Law 568, Eighty-third Congress), or the Act of August 16, 1957 (Public Law 85–151), for any fiscal year beginning after June 30, 1970, shall be available for evaluation (direction, or by grants or contracts) of any program authorized by this Act or any of such other Acts, and, in the case of allotments from any such appropriation, the amount available for allotment shall be reduced accordingly.

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CONFIDENTIALITY OF MENTAL HEALTH RECORDS

SEC. 515. (a) Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any program or activity relating to mental health education, training, treatment, services, rehabilitation, or research which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall, except as provided in subsection (e), be confidential and be disclosed only for the purposes and under the circumstances expressly authorized under subsection (b) of this section.

(b)(1) The content of any record referred to in subsection (a) may be disclosed in accordance with the prior written consent of the patient with respect to whom such record is maintained, but only to such extent, under such circumstances, and for such purposes as may be allowed under regulations prescribed pursuant to subsection (h).

(2) Whether or not the patient, with respect to whom any given record referred to in subsection (a) of this section is maintained, gives his written consent, the content of such record may be disclosed as follows:

(A) To medical personnel to the extent necessary to meet a mona fide medical emergency.

(B) To qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation, but such personnel may not identify, directly or indirectly, any individual patient in any report of such research, audit, or evaluation, or otherwise disclose patient identities in any manner.

(C) If authorized by an appropriate order of a court of competent jurisdiction granted after application showing good cause therefor. In assessing good cause the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the therapist-patient relationship, and to the treatment services. Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

(D) Where the patient is admitted on an inpatient basis, to any person upon reasonable determinations by the individual responsible for the patient's diagnostic or treatment services that (i) such person is a close friend or family member of the patient and is concerned about the patient's welfare as the result of being unable to locate the patient, (ii) the patient is incapable of making an informed decision as to whether to provide consent to disclosure, and (iii) disclosure would not be inconsistent with any arrangement that has been made for the provision of the services involved. Disclosures under this subparagraph shall be limited to the location of the patient and the patient's general physical condition.

(E) Where the patient is admitted on an inpatient basis, to a person who is a close friend or family member of a patient who is suffering from a serious physical condition involving the pos-

sibility of the patient's death if the individual responsible for the patient's diagnostic or treatment services reasonably determines that the patient is incapable of making an informed decision as to whether to provide consent to disclosure. Disclosures under this subparagraph shall be limited to the patient's location and information pertaining to such physical condition.

(F) To such persons as the individual responsible for the patient's diagnostic or treatment services reasonably considers necessary to proteect against a clear and substantial risk of imminent, serious bodily harm to the patient or others. Nothing in this subparagraph shall make such individual civilly or criminally liable for failing or refusing to make any disclosure under this subparagraph.

(G) By a department or agency of the Federal Government that has provided care and treatment services to the patient, as necessary for the purposes of the United States' obtaining, from a third party, payment for the costs of the patient's care and treatment if the United States has the right under Public Law 87–693 or other applicable law to recover such costs in the absence of an assignment from the patient and there are reasonable grounds to believe that such third party is liable for such costs.

(c) Except as authorized by a court order granted under subsection (b)(2)(C) of this section, no record referred to in subsection (a) may be used to initiate or substantiate any criminal charges against a patient or to conduct any investigation of a patient.

(d) The prohibitions of this section shall continue to apply to records concerning any individual who has been a patient, irrespective of whether or when he or she ceases to be a patient. For purposes of section 303 of this Act, persons who maintain records referred to in subsection (a) are deemed to be authorized by the Secretary to protect the privacy of individuals.

(e) The prohibitions of this section do not apply to any interchange of records—

(1) within the Armed Forces or within those components of the Veterans' Administration furnishing health care or determining eligibility for benefits or services under title 38, United States Code; or

(2) between such components and the Armed Forces.

(f) Any person who obtains a patient's consent to disclosure of a record referred to in subsection (a) of this section shall assure that such consent is informed and voluntary.

(g) Any person who violates any provision of this section or any regulation issued pursuant to this section shall be fined not more than $500 in the case of a first offense, and not more than $5,000 in the case of each subsequent offense.

(h) Except as provided in subsection (i) of this section, the Secretary shall prescribe regulations to carry out the purposes of this section. The regulations may contain such definitions, and may provide for such safeguards and procedures, including procedures and criteria for the issuance and scope of orders under subsection (b)(2)(C), as in the judgment of the Secretary are necessary or proper to effectuate the purposes of this section, to prevent circumvention or evasion thereof, or to facilitate compliance therewith.

(i) The Administrator of Veterans' Affairs, through the Chief Medical Director, shall, to the maximum feasible extent consistent with their responsibilities under title 38, United States Code, prescribe regulations making applicable the regulations prescribed by the Secretary under subsection (g) of this section to records referred to in subsection (a) of this section that are maintained in connection with the provision of hospital care, nursing home care, domiciliary care, and medical services under such title 38. In prescribing and implementing regulations pursuant to the subsection, the Administrator shall, from time to time, consult with the Secretary in order to achieve the maximum possible coordination of the regulations, and the implementation thereof, which they each prescribe.

(j) For purposes of this section—

(1) The term "identity" means—

(A) the patient's name or other data from which it could be reasonably anticipated that a person could—

(i) identify such patient, or

(ii) ascertain other data from which such patient might be identified; or

(B) a code, number, or other means use to identify the patient in relation to a record regarding him.

(2) The term "record" means data or information in any recorded medium created or maintained that—

(A) reveals or contains a patient's identity; or

(B) relates to the physical or mental health history, diagnosis, condition, treatment, or rehabilitation of a patient.

(3) The term "patient" includes a mental health research subject.

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TITLE XV—NATIONAL HEALTH PLANNING AND DEVELOPMENT

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PART B—HEALTH SYSTEMS AGENCIES

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FUNCTIONS OF HEALTH SYSTEMS AGENCIES

SEC. 1513. (a) * * *

* * * * * * *

(e)(1)(A) Except as provided in subparagraph (B), each health systems agency shall review and approve or disapprove each proposed use within its health service area of Federal funds—

(i) appropriated under this Act, the Community Mental Health Centers Act, *the Mental Health Systems Act*, sections 409 and 410 of the Drug Abuse Office and Treatment Act of 1972, or the Com-

prehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 for grants, contracts, loans, or loan guarantees for the development, expansion, or support of health resources by any entity other than the government of a State unless such resources are solely within the health service area of such agency; or

(ii) * * *

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COMMUNITY MENTAL HEALTH CENTERS ACT

TITLE II—COMMUNITY MENTAL HEALTH CENTERS

PART A—PLANNATION AND OPERATIONS ASSISTANCE

REQUIREMENTS FOR COMMUNITY MENTAL HEALTH CENTERS

SEC. 201. (a) * * *

* * * * * * *

(b)(1) The comprehensive mental health services which shall be provided through a community mental health center are as follows:

(A) Beginning on the date the community mental health center is established for purposes of this title, the services provided through the center shall include—

* * * * * * *

(iii) provision to followup care for residents of its catchment area who have been discharged from inpatient treatment at a mental health facility[;], *including—*

(I) designation of a case manager responsible for the coordination of services for each resident discharged from a public inpatient psychiatric facility and for the development of an individual treatment and services plan for such individual;

(II) pre-release consultation with respect to such individual; and

(III) preparation and submission of an annual report to the State Agency designated under section 102 of the Mental Health Systems Act describing the manner in which the needs of chronically mentally ill individuals in the catchment area are being met.

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GRANTS FOR PLANNING COMMUNITY MENTAL HEALTH CENTER PROGRAMS

SEC. 202. (a) * * *

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(d) There are authorized to be appropriated for payments under grants under subsection (a) $3,750,000 for the fiscal year 1976, $3,750,000 for the fiscal year ending September 30, 1977, $1,930,000 for the fiscal year ending September 30, 1978, $1,500,000 for the fiscal year ending September 30, 1979, [and] $1,000,000 for the fiscal year ending September 30, 1980 [.], *and $1,000,000 for the fiscal year ending September 30, 1981.*

GRANTS FOR INITIAL OPERATION

SEC. 203. (a) (1) * * *

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(d) (1) There are authorized to be appropriated for payments under initial grants under subsection (a) $50,000,000 for fiscal year 1976, $55,000,000 for the fiscal year ending September 30, 1977, $38,890,000 for the fiscal year ending September 30, 1978, $34,500,000 for the fiscal year ending September 30, 1979, [and] $35,000,000 for the fiscal year ending September 30, 1980 [.], *and $42,000,000 for the fiscal year ending September 30, 1981.*

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GRANTS FOR CONSULTATION AND EDUCATION SERVICES

SEC. 204. (a) (1) * * *

* * * * * * *

(c) There are authorized to be appropriated for payments under grants under this section $10,000,000 for fiscal year 1976, $15,000,000 for the fiscal year ending September 30, 1977, $15,000,000 for the fiscal year ending September 30, 1978, $20,000,000 for the fiscal year ending September 30, 1979, [and] $3,000,000 for the fiscal year ending September 30, 1980 [.], *and $19,000,000 for the fiscal year ending September 30, 1981.*

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PART B—FINANCIAL DISTRESS GRANTS

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AUTHORIZATION OF APPROPRIATIONS

SEC. 213. There are authorized to be appropriated $15,000,000 for fiscal year 1976, $15,000,000 for the fiscal year ending September 30, 1977, $13,500,000 for the fiscal year ending September 30, 1978 [and] $25,000,000 for the fiscal year ending September 30, 1979, *and $25,000,000 for the fiscal year ending September 30, 1981*, for payments under grants under section 211.

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Part D—Rape Prevention and Control

[Rape prevention and control] [3]

[Sec. 231. (a) The Secretary shall establish within the National Institute of Mental Health an identifiable administrative unit to be known as the National Center for the Prevention and Control of Rape (hereinafter in this section referred to as the "Center").

[(b) (1) The Secretary, acting through the Center, may, directly or by grant, carry out the following:

[(A) A continuing study of rape, including a study and investigation of—

[(i) the effectiveness of existing Federal, State, and local laws dealing with rape;

[(ii) the relationship, if any, between traditional legal and social attitudes toward sexual roles, the act of rape, and the formulation of laws dealing with rape;

[(iii) the treatment of the victims of rape by law enforcement agencies, hospitals or other medical institutions, prosecutors, and the courts;

[(iv) the causes of rape, identifying to the degree possible—

[(I) social conditions which encourage sexual attacks, and

[(II) the motives of offenders, and

[(v) the impact of rape on the victim and family of the victim;

[(vi) sexual assaults in correctional institutions;

[(vii) the actual incidence of forcible rape as compared to the reported incidence of forcible rape and the reasons for any difference in such incidences; and

[(viii) the effectiveness of existing private and local and State government educational, counseling, and other programs designed to prevent and control rape.

[(B) The compilation, analysis, and publication of summaries of the continuing study conducted under subparagraph (A) and the research and demonstration projects conducted under subparagraph (E). The Secretary shall annually submit to the Congress a summary of such study and projects together with recommendations where appropriate.

[(C) The development and maintenance of an information clearinghouse with regard to—

[(i) the prevention and control of rape;

[(ii) the treatment and counseling of the victims of rape and their families; and

[(iii) the rehabilitation of offenders.

[(D) The compilation and publication of training materials for personnel who are engaged or intend to engage in programs designed to prevent and control rape.

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[3] This section is redesignated as Section 456 of the Public Health Service Act.

[(E) Assistance to community mental health centers and other qualified public and nonprofit private entities in conducting research and demonstration projects concerning the prevention and control of rape, including projects (i) for the planning, developing, implementing, and evaluating of alternative methods used in the prevention and control of rape, the treatment and counseling of the victims of rape and their families, and the rehabilitation of offenders; (ii) for the application of such alternative methods; and (iii) for the promotion of community awareness of the specific locations in which, and the specific social and other conditions under which, sexual attacks are most likely to occur.

[(F) Assistance to community mental health centers in meeting the costs of providing consultation and education services respecting rape.

[(2) For purposes of this subsection, the term "rape" includes statutory and attempted rape and any other criminal sexual assault (whether homosexual or heterosexual) which involves force or the threat of force.

[(c) The Secretary shall appoint an advisory committee to advise, consult with, and make recommendations to him on the implementation of subsection (b). The recommendations of the committee shall be submitted directly to the Secretary without review or revision by any person without the consent of the committee. The Secretary shall appoint to such committee persons who are particularly qualified to assist in carrying out the functions of the committee. A majority of the members of the committee shall be women. Members of the advisory committee shall receive compensation at rates, not to exceed the daily equivalent of the annual rate in effect for grade GS–18 of the general schedule, for each day (including traveltime) they are engaged in the performance of their duties as members of the advisory committee and, while so serving away from their homes or regular places of business, each member shall be allowed travel expenses, including per diem in lieu of subsistence, in the same manner as authorized by section 5703 of title 5, United States Code, for persons in Government service employed intermittently.

[(d) For the purpose of carrying out subsection (b), there are authorized to be appropriated $7,000,000 for fiscal year 1976, $10,000,000 for the fiscal year ending September 30, 1977, $7,880,000 for the fiscal year ending September 30, 1978, $8,000,000 for the fiscal year ending September 30, 1979, and $9,000,000 for the fiscal year ending September 30, 1980.]

PART E—GENERAL PROVISIONS

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[STATE PLAN

[SEC. 237. (a) A State plan for the provision of comprehensive mental health services within a State shall be consistent with the State health plan in effect for such State under section 1524(c) of the Public

Health Service Act and shall be comprised of the following two parts:

[(1) An administrative part containing provisions respecting the administration of the plan and related matters. Such part shall—

[(A) provide for the designation of a State advisory council to consult with the State agency in administering such plan, which council shall include (i) representatives of nongovernment organizations or groups, and of State agencies, concerned with the planning, operation, or use of community mental health centers or other mental health facilities, and (ii) representatives of consumers and providers of the services of such centers and facilities who are familiar with the need for such services;

[(B) provide that the State agency will make such reports in such form and containing such information as the Secretary may from time to time reasonably require, and will keep such records and afford such access thereto as the Secretary may find necessary to assure the correctness and verification of such reports;

[(C) provide that the State agency will from time to time, but not less often than annually, review the State plan and submit to the Secretary appropriate modifications thereof which it considers necessary; and

[(D) include provisions, meeting such requirements as the Civil Service Commission may prescribe, relating to the establishment and maintenance of personnel standards on a merit basis.

[(2) A services and facilities part containing provisions respecting services to be offered within the State by community mental health centers and provisions respecting facilities for such centers. Such part shall—

[(A) be consistent with the provisions of the State plan prepared in accordance with section 1524(c)(2) of the Public Health Service Act or the State plan approved under section 314(a) of such Act, whichever is applicable, relating to the provision of mental health services;

[(B) set forth a program for community mental health centers within the State (i) which is based on a statewide inventory of existing facilities and a survey of need for the comprehensive mental health services described in section 201(b); (ii) which conforms with regulations prescribed by the Secretary under section 236; and (iii) which shall provide for adequate community mental health centers to furnish needed services for persons unable to pay therefor;

[(C) set forth the relative need, determined in accordance with the regulations prescribed under section 236, for the projects included in program described in subparagraph (B), and, in the case of projects under part C, provide for the completion of such projects in the order of such relative need;

[(D) emphasize the provision of outpatient services by community mental health centers as a preferable alternative to inpatient hospital services; and

[(E) provide minimum standards (to be fixed in the discretion of the State) for the maintenance and operation of centers which receive Federal aid under this title and provide for enforcement of such standards with respect to projects approved by the Secretary under this title.

[(b) The State agency shall administer or supervise the administration of the State plan.

[(c) A State shall submit a State plan in such form and manner as the Secretary shall by regulation prescribe. The Secretary shall approve any State plan (and any modification thereof) which complies with the requirements of subsection (a). The Secretary shall not finally disapprove a State plan except after reasonable notice and opportunity for a hearing to the State.

[(d) (1) At the request of any State, a portion of any allotment or allotments of such State under section 227 for any fiscal year shall be available to pay one-half (or such smaller share as the State may request) of the expenditures found necessary by the Secretary for the proper and efficient administration of the provisions of the State plan approved under this section which relate to projects under part C for facilities for community mental health centers; except that not more than 5 per centum of the total of the allotments of such State for any fiscal year, or $50,000, whichever is less, shall be available for such purpose. Amounts made available to any State under this paragraph from its allotment or allotments under section 227 for any fiscal year shall be available only for such expenditures (referred to in the preceding sentence) during such fiscal year or the following fiscal year. Payments of amounts due under this paragraph may be made in advance or by way of reimbursement, and in such installments, as the Secretary may determine.

[(2) Any amount paid under paragraph (1) to any State for any fiscal year for administration of the provisions of an approved State plan shall be paid on condition that there shall be expended from State sources for each year for administration of such provisions not less than the total amount expended for such purposes from such sources during the fiscal year ending June 30, 1968.]

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